Future-proofing: Exploring the value of a therapeutic recreation positive psychology intervention for supporting youth experiencing mental health challenges

Lauren C. Cripps, BRLS., M.A.

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Dedication

For Abby

My goal in life is to be the person you already thought I was…

Thank you for inspiring this journey, you are with me always!

Abstract

In Canada, suicide remains the second leading cause of death for individuals aged 15 to 24, exceeded only by unintentional injuries (accidents). In 2012, suicide accounted for 15% of deaths among youth aged 10-14 years, 29% among youth aged 15-19 years and 23% among young adults aged 20-24 (Statistics Canada, 2017). Recovery supports the development of a meaningful life (as described by the individual) that includes enhanced traits and practices that are specifically intended to maintain one's level of satisfaction in everyday life, while supporting the management of recurring symptoms and/or changes in current life circumstances (Andresen, Oades, & Caputi, 2011; Kleiber, Hutchinson, & Williams, 2002; McCormick & Iwasaki, 2008; McCormick & Iwasaki, 2008; McCormick, 1999). This recovery-oriented project was a qualitative, interpretative phenomenological study guided by the evidenced-informed process as a framework for program design, implementation and evaluation. This project sought to critically explore mental health as it pertains to adolescents through the design, implementation and evaluation of a therapeutic recreation intervention designed for youth living in a residential treatment setting.

This project provides evidence that the BYBS-Y program has the potential to support change with the participants. This project also demonstrates new learning and is an illustration of the potential connection between a strengths perspective and supporting essential tasks assigned to development and recovery. By implementing a three-phase process this research shows the value of feedback from both practitioners and clients, affirming that our greatest insights are always gained from those with lived experience. Finally, this project provides evidence for the contribution of TR services in the recovery process, suggesting that by focusing on the development of skills and capacities that are likely to generate emotion, highlight strengths, support choice and create opportunities for positive social connections, it is likely that youth can

increase the resiliency necessary to buffer the effects of chronic symptoms and in turn begin to envision (and obtain) a life that includes, but is not defined by illness.

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Thank you to my family for never giving up on me and finding the space to love me through even the toughest moments of the past five years! William, I am so proud to have you as my partner in parenting, life and love. Nyla, Emma, Willa and Luca being your mom will forever be my greatest accomplishment! May you believe that anything is possible...reach for the stars and know I will be waiting in the clouds to catch you anytime you fall. Finally, to my mom and dad, thank you for never giving up on me. Your unconditional love and support over the past five years made this messy journey possible and I hope you know how grateful I am for you both.

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Chapter 1 – Introduction

The Problem of Mental Illness

In Canada, 1 in 5 Canadians will experience a mental illness in their lifetime, with 1 in 2 having previous experience with or currently experiencing symptoms consistent with mental illness by the time they reach age 40 (Smetanin, Stiff, Briante, Adair, & Khan, 2011). Currently, mental health is the leading cause of disability and premature death in the country, accounting for approximately thirty percent of all disability claims and seventy percent of total health care costs (Government of Canada, 2006; Lim, Jacobs, Ohinmaa, Schopflocher, & Dewa, 2008). The burden of mental illness and addiction in Ontario is 1.5 times higher than all cancers combined (Canadian Institute for Health Information, 2007). Currently, almost 14% of Canadians 15 years or older report having a disability that impacts their daily activities, and in 2009 10.1% of the Canadian population aged 15 or older reported symptoms consistent with (at least one of) depression, bipolar disorder, generalized anxiety disorder, abuse of or dependence on alcohol, illicit or prescription drugs with the most common symptoms being reported among those aged 15 to 24 being mental/psychological (Statistics Canada, 2012).

The Government of Canada (2006) reported that 70% of all mental health problems have their onset during childhood or adolescence. Boak, Hamilton, Adlaf, Herderson, and Mann (2016) found that 34% of Ontario high school students indicate moderate-to-serious levels of distress consistent with symptoms of anxiety and depression, while 14% of Ontario high school students indicate serious levels of psychological distress. Meanwhile, Pearson, Janz and Ali (2013) suggest that adolescents (and young adults) aged 15 to 24 are more likely to experience mental illness and or/substance use disorders than any other age group in Canada.

Nearly 4,000 Canadians die by suicide each year, with an average of 11 suicides per day (Statistics Canada, 2017). In Ontario, about 2% of adults and 12% of high school students report having seriously contemplated suicide in the past year, with an additional 3% of high school students reporting having attempted suicide (Boak et al., 2016; Lalomitea, Hamilton, Adlaf, & Mann, 2016). For individuals aged 15 to 24, suicide remains the second leading cause of death, exceeded only by unintentional injuries (accidents). In 2012, suicide accounted for 15% of deaths among youth aged 10-14 years, 29% among youth aged 15-19 years and 23% among young adults aged 20-24 in Canada (Statistics Canada, 2017).

Current literature links social issues to mental illness in Canada, suggesting that individuals who are of low socioeconomic status are three to four times more likely to report fair to poor mental health and less likely to experience recovery, than those of high socioeconomic status (Mawani & Gilmore, 2010). Waddell, McEwan, Shepherd, Offord, and Hua (2005) estimated that 75% of children with mental disorders do not access specialized treatment services while only one-third of individuals in need of mental health support services will actually receive them at all. In 2013/14, mental disorders accounted for 5% of all emergency department visits and 18% of all inpatient hospitalizations for children and youth aged 5 to 24, and wait times for outpatient support services in Ontario averaged six months to a year (Canadian Institute for Health Information, 2015; Children's Mental Health Ontario, 2017; Waddell et al., 2005)

Further, there are a number of risk factors that make children and adolescents particularly vulnerable to psychopathology and subsequently lifetime disability. These factors include, but are not limited to poverty, inconsistent/deficient parenting, parental mental illness, abuse, childhood violence, death of a parent, breakup of the family, homelessness, community disasters, early pregnancy and neonatal complications (Shatkin, 2015). As such, there may be an unspoken connection between adolescent mental health and rising rates of disability in Canada. Perhaps,

early intervention and the availability of effective mental health services for adolescents is of particular value if we are to reduce the impact that mental health is having on the Canadian social and economic systems (Government of Canada, 2006), not to mention the quality of life for those affected by illness.

Defining Recovery

There are a number of definitions for recovery arising from the mental health literature over the past few decades. More recent literature recognizes recovery as a process, while early literature supports the outcome dimension (Davidson & Roe, 2007; Ralph & Corrigan, 2005). As a process, recovery is regarded as a personal journey that involves the reduction of clinical symptoms and the facilitation of personal development that increases daily functioning (Andresen, Oades, & Caputi, 2011; Ralph & Corrigan, 2005; Wellesley Institute, 2009). As an outcome, recovery is suggested to be an end result and/or naturally occurring phenomenon produced by particular environmental conditions that include a positive state of mind, satisfaction in education or vocational pursuits, healthy family/social relationships and ongoing engagement in meaningful leisure experiences (Ontario Ministry of Health and Long-Term Care, 2011; Ralph & Corrigan, 2005). Interestingly, neither of these perspectives on recovery identify elimination of symptoms as a necessary component of living well. As such, for the purpose of this study, recovery is not the return to a pre-morbid state, but rather a highly individualized process of learning to live a satisfying life with mental illness.

The pathway from mental dysfunction to living well with mental illness is not linear but rather it is a multi-directional process that accounts for recurring/worsening symptoms and supports individuals as they face varying degrees of adversity throughout their life (Andresen, Oades, & Caputi, 2011; Ralph & Corrigan, 2005). Recovery supports the development of a meaningful life (as described by the individual) that includes enhanced traits and practices that

are specifically intended to maintain one's level of satisfaction in everyday life, while supporting the management of recurring symptoms and/or changes in current life circumstances (Andresen, Oades, & Caputi, 2011; Kleiber, Hutchinson, & Williams, 2002; McCormick & Iwasaki, 2008; McCormick & Iwasaki, 2008; McCormick, 1999).

Clarifying Language

One of the challenges often faced when engaging in a conversation such as this is the misuse of terminology. For the purpose of this this paper, I define mental health as a state of well-being in which an individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. Mental health includes capacities in emotional, psychological, and social domains. It affects how one thinks, feels, and acts. It is a predictor of our ability to handle stress, relate to others, and make positive choices (Anthony, 1999; Shatkin, 2015). Mental health is the encompassment of physical, mental and social well-being and not merely the absence of disease or infirmity (Andresen, Oades, & Caputi, 2011; Anthony, 1999). Mental illness however, is a specific component of mental health that involves changes in psychological pathology (brain function) that in turn influence changes in thinking, emotion or behavior and often impacts one's ability to function in daily living (Shatkin, 2015). There is an intersection that exists between mental health and mental illness, in that it is possible to have poor mental health without the presence of formal illness, and it is also possible to have good mental health but live with a mental illness. Both mental health and mental illness exist on continuum that ranges from psychological dysfunction to flourishing (Keyes, 2002; 2005; Lyubomirsky & Layous, 2013; Lyubomirsky, 2007). For the purpose of this research, the term mental health is an umbrella term that includes individuals who demonstrate risk factors for and individuals with symptoms of mental illness.

Leisure and Therapeutic Recreation

Leisure is a domain of life that is most likely to be perceived as relatively free from external pressures, that is likely to generate positive emotion, and that can help people to identify strengths, interests, and talents (Carruthers & Hood, 2007; Kleiber, 1999). Leisure, well used, has the potential to contribute significantly to the creation of meaningful social networks, community connections and a sense of enjoyment in life (Carruthers & Hood, 2007), all of which are central to the recovery process. However not all leisure engagements support well-being, and in fact, some leisure choices can be detrimental to well-being, hence the notion of leisure well-used.

Leisure provides an opportunity for transcending negative life events and provides context for freedom of self-expression and self-directed development (Kleiber, 1999). As such, leisure, well used, could provide an outlet for self-acceptance for individuals with mental illness that could proactively support recovery and living well despite the stigmatization that exists within society. In addition, leisure may also provide an opportunity for social connections, further supporting the acquisition of happiness and resilience in daily living. A focus on positive emotion and strengths is supported by the work of Davidson et al. (2006), who proposed that positive life experiences promote resilience and adaptation, and that through play and pleasure, individuals with mental illness build up their restorative power, self-efficacy and social agency which contribute directly to an overall sense of well-being. Carruthers and Hood (2007; 2013) suggest that leisure is a means through which individuals can experience positive emotions that are central to well-being, linking positive emotion to increased levels of physical, emotional and social health.

Shatkin (2015) proposed resiliency as a key factor in combating and mitigating mental health challenges among children and adolescents, noting one's resilience factor as a variable

that decreases the likelihood of negative outcomes despite the individual being at risk for psychopathology. Fredrickson (1998, 2001) presents the *broaden and build theory* as the foundation for creating resilience. Within this theory, she proposes that the experience of positive emotion on a daily basis facilitates the development of a protective barrier against adversity that assists in buffering difficult life events. Within this model, Fredrickson (1998, 2001) iterates the value of positive emotion through momentary experiences in everyday life. As individuals develop the capacity to notice positive emotion, they are able to widen their perceptual field and thus expand their thought and action possibilities. Similar findings were echoed by Shahar and Davidson (2003), who examined the role of positive life events in the recovery process from severe mental illness and further identified that individuals who report a higher number of positive life events also report higher levels of self-esteem, sense of self and overall quality of life. Kleiber (1999) proposed leisure as valuable for adolescent development and emphasized leisure as a space most likely to generate positive emotion, thereby connecting leisure (well-used) to one's own resiliency. In Chapter 2, I will explore the unique attributes of the youth population and the connection between leisure and the supportive role it could play in facilitating this population in living well.

Therapeutic recreation (TR) is an allied health profession that focuses on choices and engagement in one's discretionary time and is particularly useful for supporting individuals with their free time engagements. The purpose of the field is to enhance individuals' ability to engage in meaningful, freely chosen leisure activities that increase outcomes such as positivity, autonomy, optimism and social engagement, to name a few. Effective TR practice addresses psychological, emotional and social aspects of life through the facilitation of services that connect individuals to activities that are personally gratifying and promote internal desires for change (Anderson & Heyne, 2012a; Carruthers & Hood 2007). Within this project I will

investigate the role of leisure in living well with mental illness, through TR services, for adolescents living in a group home for youth facing significant mental health challenges. This project seeks to critically explore mental health as it pertains to youth, more specifically, I will examine the role of leisure in supporting mental health and explore the value of purposeful integration of therapeutic recreation services for youth accessing a local mental health organization.

Project Overview

This project explored the primary research question: *How might a therapeutic recreation intervention designed to [broadly] support the development of a positive personal narrative impact adolescents' perceptions of living well with mental illness?* The purpose of this research is to develop, implement and evaluate a treatment program for adolescents with mental illness that validates current positive psychology and recovery literature and supports recovery-oriented therapeutic recreation practice. This study utilized therapeutic recreation interventions that incorporated factors and practices that were associated with living-well, and that supported the development of the capacities deemed to be necessary to create a positive identity while managing a mental illness.

In accordance with best practice, the therapeutic recreation program was developed, modified and evaluated using the three phases of evidence informed practice, (Anderson & Heyne, 2012b). More specifically, a therapeutic recreation intervention was adapted based on the expressed needs of youth accessing residential treatment services (phase one). The topical areas of the program were then validated through the solicitation of practitioner feedback (phase two), and the program was then piloted using multi method data collection to evaluate its effectiveness.

Over the past decade I have maintained a particular interest in positive psychology and its alignment with recovery-oriented TR practice. Within my master's thesis I examined the experience of mental illness and recovery in an effort to understand the factors that support living well with mental illness. My findings led to the development of a framework that illustrated strategies that my co-researchers had employed throughout their recovery. My project focused on individuals who had a mental illness diagnosis and were living well, in order to better understand their choices related to engagement in meaningful life activities. This focus was also congruent with the professional aims of therapeutic recreation and the results of my master's research contribute to the foundation for my doctoral project.

Moreover, what I have come to discover through my own experience in mental health, both personally and professionally, is that the pathway from mental health challenges to living well with mental illness is neither pre-defined nor linear but rather a multi-directional process that accounts for recurring/worsening symptoms and supports individuals as they face varying degrees of adversity throughout their life. The goal of recovery-oriented care should therefore be to focus on enhancing one's capacity to live-well rather than to eliminate deficits. Hope, positive identity, pleasure in everyday life, agency/autonomy, and establishing social connections are positively correlated with leisure, and therefore are elements of recovery worthy of further exploration (Andresen, Oades, & Caputi, 2011; Carruthers & Hood, 2007; Davidson, Tondora, Staeheli Lawless, O'Connell, & Rowe, 2009; Kleiber, 1999).

Chapter 2 – Literature Review

Chapter one provided a brief overview of the problem of mental illness in Canada, in particular for the adolescent population. Not only do children and adolescents have exceptionally long wait times for service, the services themselves are unspecialized. Indeed, evidenced-based interventions are of particular value in the health care arena, regardless of the population, however, it is possible that evidence-based interventions that have demonstrated effectiveness with the adult population are not a universal fit for adolescents. This chapter will explore the unique attributes and needs of the adolescent population and illustrate the parallel relationship that exists between the central tenets of development and recovery with mental illness and furthermore, illustrate that both domains (development and recovery) must be addressed in order for adolescents to progress towards living well.

Adolescence is a time of significant change for young people (biologically, socially, emotionally and environmentally), and, relative to any other life stage, these concurrent changes are often happening at an accelerated rate (Coleman, 1978; Hendry & Kloep, 2012; Steinberg, 1985; 2017; 2020). Adolescence is equally a period of particular challenge both for youth and those around them. It is not without coincidence that Hall (1904) described this life-stage through the lens of "storm and stress," suggesting that adolescence is when human beings shift from being beast-like to being civilized. As young people begin to experience change across bio-psycho-social domains, they are influenced by many outside factors such as family, friends, education, community, culture, and religion, to name a few. As such, adolescence is a life-stage during which there many factors to consider that might pose a threat to one's mental health (Shatkin, 2015). While indeed each adolescent (or "teen") is unique in personality, interests and abilities, Steinberg (2017; 2020) suggests there are many developmental issues that transcend culture, sex and ethnicity, without exception, and are better understood through various

developmental theories. This section will explore the core developmental theories as they best relate to the various markers of adolescence. More simply, I will explain *who makes up the adolescent population and what makes them unique.*

Steinberg (2017; 2020) describes change as being the pinnacle of adolescence, suggesting that there are three primary markers that distinguish the transition from child to adulthood: (1) the onset of puberty, (2) advancement of thinking, and (3) transition into new social roles. Biological transitions, otherwise known as physical maturation, marked by the onset of puberty are often the most tangible representation of adolescence. A series of hormonal changes take place between approximately ten and fourteen years of age. These hormones trigger the development of secondary sex characteristics such as breasts in females, a deeper voice in males and visibility of facial and/or bodily hair for both sexes. Puberty is considered complete when one has developed the ability to conceive children. Cognitive transitions are arguably more complex as they are represented by one's capacity to develop and execute complex thought. These changes, some suggest, take place over a longer period of time than biological changes as they involve the maturation and networking of multiple brain regions. Lastly, and perhaps the most culturally influenced, is social transitions. These transitions are marked in society by distinguishing expectations between child and adult. Specifically, social transitions are represented by changes in one's rights, privileges, and responsibilities (Steinberg, 2017; 2020).

Adolescent Development

Social scientists who study adolescence have historically differentiated among three stages, early, middle and late adolescence, as a way to better organize the immense biological, psychological and social growth that takes place during this life stage. More recently, however, some scientists have added a fourth phase to their discussions, emerging adulthood (Arnett, 2004). According to Steinberg (2014; 2020) adolescence was once unanimously associated with

the chronological “teen” years and therefore considered to be complete before age twenty. Over the past century, scientists have come to recognize that physical maturation is often starting at an earlier age (10 to 14 years) while psycho-social maturation now is extending into the mid-twenties. For the purpose of this research, I will define adolescence in accordance with current developmental literature that is representative of western culture. As such, adolescence begins with puberty and ends with the transition to adult roles, including but not limited to, workforce entry and marital-type partnership (Steinberg, 2017; 2020). For the purpose of clarity, adolescence will be explored using early (10-14 years), middle (15-17 years), and late (18-21+ years) stage categories.

Psychosocial development is of particular interest when exploring mental health in the adolescent population as it is often a predictor of, and challenged by, the onset of mental illness (Shatkin, 2015). There are five broad areas that represent the psychosocial behaviour of youth across the early, middle and late stages of adolescence: (1) identity, (2) autonomy, (3) intimacy, (4) sexuality and (5) achievement, each of these will be further explored in the context of development and plausible connections to mental health.

Identity. Identity is the domain of psychosocial development that involves self-esteem, self-concept and sense of who one is (Adams, 2000; Adams & Marshall, 1996; Steinberg, 2017; 2020). Identity should be understood beyond the simplicity of one’s sense of self, as acceptance is of equal value within this domain. Within this domain, adolescents experience a need for external validation that marks them as special or unique and confirms the value they offer to the world around them and life ahead of them. Identity development continues across the lifespan, however identity is first established during the adolescent formative years, which makes this experience foundational to one’s future growth and development (Steinberg, 2017; 2020).

Erikson (1968) was the first theorist to emphasize psychosocial conflicts in development. His theory proposed eight stages in psychosocial development across the lifespan: (1) trust vs. mistrust, (2) autonomy vs. shame and doubt, (3) initiative vs. guilt, (4) industry vs. inferiority, (5) identity vs. role confusion, (6) intimacy vs. isolation, (7) generativity vs. stagnation, (8) ego integrity vs. despair. Each stage is characterized by a crisis that arises as a result of the tensions that are inevitable between the "internal forces of biology and the demands of society" (Steinberg, 2017, p. 9). As such, Erikson's theory suggests development in adolescence is vastly dependent on the arousal and resolution of identity.

Bronfenbrenner (1979) emphasizes the impact of culture on identity development, a notion first brought forth by Mead (1928). Through the Ecological model, Bronfenbrenner suggests that context is particularly impactful on development, as the influence of family, peers, religion, education, the media, community and world events all shape the development of one's identity. He believed there is interaction between the individual and five ecological systems, each having gradient levels of influence on development, beginning with the most significant-microsystem and ending with the most broad chronosystem. The microsystem consists of the activities and interactions that are within one's primary surroundings (e.g. parents, school, friends, activities). The mesosystem is the relationships that exist between the entities that make up the microsystem that influence one's experiences (e.g. parents interacting with teachers and the impact of the subsequent influence that can have on the child's education). The exosystem is made up of the social institutions which affect development indirectly but are responsible for creating social hegemony (e.g. parents' career, extended family network, mass media and community resources). The macrosystem populates the broader cultural values and laws which govern a particular society (e.g. laws and governmental resources). Finally, the chronosystem accounts for the significant changes that occur over time in one's life personally and culturally

(e.g. the birth of a sibling, a major world war). As such, Bronfenbrenner's theory suggests that development in adolescence is particularly vulnerable to external factors and therefore identity is a by-product of the environment in which one most often exists.

Steinberg (2017; 2020) echoes many of the same sentiments, suggesting that identity is influenced by external factors and developed through independent experiences. Early adolescents begin to develop their identity by exploring the world beyond their nuclear family unit. As such, friendships become increasingly valuable to teens as part of their search for new people to love and to be loved by. Within this context, early adolescents are highly influenced by peer groups and relationships with peers hold particular value which is most often displayed through their personal interests and appearance, such as clothing and aesthetics. By approximately fifteen years of age, middle adolescents are confident in their social skills and begin to take on a pro-social role that emphasizes their current peer group or inspires the development of new peer relationships with people who share similar personal interests. Further, middle adolescents begin to demonstrate a preoccupation with appearance and one's own body as part of their identity formation. By late adolescence, identity and interests become more concrete and individuals are able to better navigate day to day interpersonal connections. By this stage, late adolescents have a more developed sense of humour, are capable of abstract thought and demonstrate greater levels of emotional stability. Identity is expressed through pride, performance and accomplishments, as one prepares to embrace their transition to adult roles.

Autonomy. Autonomy is the domain of psychosocial development that involves the development and expression of independence (Steinberg, 2017; 2020). Within this domain, adolescents establish themselves as a self-governing body through which they relate to others and begin to explore a code of conduct or expectations that is often misunderstood and misrepresented by outsiders such as parents, siblings, teachers and other authority figures.

According to Steinberg (2017; 2020) there are three aspects that are integral to the establishment of autonomy: (1) decreasing emotional dependence on parental figures, (2) independent functionality and (3) the establishment of one's own personal values and morals.

Kohlberg (1958) proposed stages of moral development through the initial findings of his doctoral research and continued to explore moral development for decades to follow. Simply, stated, Kohlberg believed that moral reasoning could be classified into three levels consisting of a total of six stages. He suggested that individuals progress through moral development in a linear fashion without the possibility of skipping stages. Accordingly, the pre-conventional stages are representative of child development. Stage one, obedience and punishment, is marked by elementary school with children being hyper focused on behaving in ways that persons of authority (e.g. parents, teachers, principals) tell them to. In the second stage, individuals, instrumentalism, and exchange are slightly more advanced and also involve acting in ways that include one's own interests. The conventional level stages are achieved in the adolescent years with stage three, "good girl/boy," being characterized by social approval, while the fourth stage, law and order, is about being law abiding and responding to obligations of duty. Lastly, the post-conventional stages are achieved sometime between late adolescence and early adulthood. The fifth stage, social contract, is focused on the understanding of and being interested in the welfare of others, and in the sixth stage, principled conscience, the individual is concerned with the demands of personal conscience and one's ability to translate this into daily interactions with their surroundings. Notably, Kohlberg argued that pre-conventional and conventional levels were integral aspects of development. Throughout his entire career he continued to question the frequency under which the principled conscience was ever actually achieved (Muuss, 1988).

Summary of Kohlberg's stages of moral development theory:

Level:	Stage:
Pre-conventional	1 – obedience and punishment
	2 – individualism, instrumentalism, and exchange
Conventional	3 – "good boy/girl"
	4 – law and order
Post-conventional	5 – social contract
	6 – principled conscience

Steinberg (2017; 2020) proposed that early adolescence marks the establishment of autonomy by distancing/withdrawing from parental figures and younger siblings. Autonomy is demonstrated through rule breaking and limit testing as adolescents begin to come to terms with the realization of their parents' imperfections. Ironically, with their ability to emotionally regulate still underdeveloped, early adolescents are noted for reverting to childish behaviours as they explore independence, face barriers and experience stress. Further, it is within this age group (10-14 years) that adolescents begin to experiment with cigarettes, marijuana and alcohol (Stats Canada, 2012), with frequency of use increasing through the later stages of adolescence, a notion that aligns well with Kohlberg's (1958) conventional stages of identity ("good boy/girl;" law and order). As Shatkin (2015) notes, risk taking behaviour peaks during the adolescent years, with the top three causes of teen death in North America being accident (risk-behaviour), suicide and homicide.

In an effort to display autonomy, middle adolescents are concerned with the development of personal ideals, through which they select and connect to role models. Middle adolescents are

aware of their own imperfections, but this does not shift the lowered opinion they have of their own parents and as such remain withdrawn from their primary care-givers. Steinberg (2017; 2020) suggests that middle adolescents are negotiating the tension between unrealistic expectations (disappointment) and ongoing worries about their own failure. This tension, however, often supports their increased interest in intellectual pursuits as they begin to develop career interests. By late adolescence, they have become self-reliant and have the ability to make sound decisions. There are, however, continued thoughts surrounding future life roles as they prepare to embrace adulthood. Late adolescents have clearly defined work habits and take pride in their work performance with particular career interests established (Hendry & Kloep, 2012; Kerig, Schulz, & Hauser, 2012; Mitchell, 2001; Steinberg, 1985; 2017; 2020).

Intimacy. Intimacy is the domain of psychosocial development that involves the formation, maintenance and termination of close relationships (Steinberg, 2017; 2020). The development of**,** and capacity to**,** maintain peer and romantic relationships is a cornerstone of the adolescent experience. There is a particular emphasis on **a** need for openness, honesty, loyalty and exchange of confidences within adolescent**,** peer**,** and, subsequently, romantic relationships (Mitchell, 2001). Early adolescents begin to explore this domain by emphasizing the value of peer relationships, while detaching from primary care givers and dating begins to have increased importance. The emotional dysregulation of early adolescence is often expressed through moodiness and, as a result, feelings are more likely to be expressed through actions than words (Kerig, Schulz, & Hauser, 2012). Conversely, middle adolescents tend to examine experiences inwardly, and are most likely to express feelings through writing. It is during this middle adolescence that private journals become a space to express intense emotions, as well as sharing with peers. It is during middle adolescence that parents experience sadness from the sense of loss and/or rejection they feel as a result of the relationships their teen is forging independent of them

(Adams, 2000). By late adolescence the ability to relate to and be compassionate towards others has developed and the consideration of another's feelings permits decisions beyond the self (Mitchell, 2001). Late adolescents further demonstrate intimacy through their ability to express feelings through words (both verbal and written), to negotiate conflict, and their willingness to compromise with others (Hendry & Kloep, 2012; Kerig, Schulz, & Hauser, 2012; Mitchell, 2001; Steinberg, 1985; 2017; 2020).

Sexuality. Sexuality is the domain of psychosocial development that involves the establishment and expression of sexual feelings (Steinberg, 2017; 2020). Accordingly, sexuality is regarded as a particularly important aspect of development, as it is the catalyst to advancing relationships between adolescents and their peers but more importantly it raises the need for internal questions about one's identity, relationship boundaries, and sexual morals and values (Adams, 2000; Thomas, 1996).

Early adolescents display sexuality through blushing, shyness and modesty, equally, as their interest is sparked by another they begin to show off (Steinberg, 2017; 2020). Early adolescents first express sexual curiosity with their own bodies through masturbation and through this exploration they experience worries about the normalcy of their body. The experience of exploring one's own body drives a sense of curiosity about others, while creating barriers based on one's own insecurities (Hendry & Kloep, 2012; Steinberg, 2017; 2020). Similarly, middle adolescents worry about their attractiveness to others and they are driven by their need to feel desired (and accepted). Middle adolescents have a more clearly defined sexual orientation with those who are not heterosexual often experiencing internal conflicts. Middle adolescents have the ability to display tenderness towards a desired partner, underpinned by fears of rejection. Middle adolescents tend to have the highest frequency of changing relationships, they begin to explore sexual interactions with others, and experience feelings of love and passion

for the first time (Adams, 2000; Hendry & Kloep, 2012; Kerig, Schulz, & Hauser, 2012; Mitchell, 2001). In contrast, late adolescents are primarily focused on the attainment and maintenance of serious relationships. Within this context, late adolescents are forced to evaluate concepts of monogamy in accordance to their already established morals and values. Late adolescents have a well-developed capacity for connectedness with romantic partners, a clear sexual identity that may or may not be actively expressed and most are sexually active (Muuss, 1988; Muuss, Velder, & Porton, 1996; Rice & Dolgin, 2002; Steinberg, 2001; 2017; 2020).

Sigmund Freud's work is best known for his psychosexual theory of development. Within this theory, he poses that sexual instincts often conflict with social expectations, and it is within this tension that development progresses. Freud's linear model suggests that psychosexual development begins in early infancy and continues as the individual passes through stages named according to the zone of the body responsible for libido satisfaction during that particular stage of development (Berg, 2003). Like Hall (1904), Freud saw adolescence as a period of upheaval. Specifically, he suggested that puberty thrusts adolescents into a psychological crisis by reviving previous sexual conflicts that existed in the earlier years of development that were buried in the unconscious mind (Muuss, 1988). However, as Steinberg (2017; 2020) addresses, Sigmund Freud actually had very little to say about adolescence and it was his daughter Anna Freud (1958) who explored the notion of adolescent development in her own work. Both scholars recognize adolescence as a period of sexual excitement and anxiety. Anna Freud (1958), however, shifted from her father's psychosexual focus, to the need for detachment from parents in order for normal development to take place (Adams, 2000; Hendry & Kloep, 2012; Muuss, 1988; Muuss et al., 1996; Rice & Dolgin, 2002; Steinberg, 2001; 2017).

Achievement. Achievement is the domain of psychosocial development that pertains to the behaviours and feelings associated with evaluative situations (Steinberg, 2017; 2020).

Adolescence is a life stage associated with crucial decisions, many of which have long-term consequences. Piaget (1950) was among the first to suggest that the final stages of cognitive development take place in adolescence. Piaget's model of cognitive development described the sequential changes in thinking that take place from infancy to adulthood. This model suggests that adolescence aligns with the formal operational stage where thinking evolves past concrete actualization to incorporate logical and abstract processes. Thus, Piagetian theory would suggest that achievement in adolescence is influenced by the biological changes that permit advanced thinking, and the intellectual environment that supports the development of such capacities (Adams, 2000; Keirg, Schulz & Hauser, 2012; Steinberg, 2017; 2020; Thomas, 1996).

Across early, middle and late adolescence, the majority of decisions are rooted in interpersonal relationships and career aspirations. The notion of achievement is particularly prominent across all three stages with regards to academic performance, more so now than ever before (Gibson-Cline, 1996). The Canadian education system includes the exploration of careers during the early adolescent years, while middle adolescents are tasked with course selection and material that aligns with their post-secondary program requirements and late adolescents are often beginning college/university before reaching legal voting age. What is particularly striking about the notion of achievement within the context of the adolescent population is how dependent it is on academic performance and one's ability to display capacities through the lens of others. This leads to a questioning of the punitive nature of our system and the lasting effects it could have on adolescents experiencing mental health challenges. What happens to the teen who learns differently or lives with a mental illness that might inhibit their ability to perform under the societal pressure to achieve a particular norm?

Indeed, identity, autonomy, intimacy, sexuality and achievement are domains worthy of discussion, and it seems possible that there is a relationship between each of these domains that

is both catalyzed and threatened by the others. The third section of this chapter will explore the complexities and interplay of these five domains with regard to mental health as this may be a challenge that is unique to adolescence.

Understanding Mental Health

Mental illness is abnormal psychiatric pathology that manifests symptoms that may include: auditory hallucinations, delusions, thought disorder, chronic sadness, mania, thoughts of harming self or others, and/or emotion dysregulation and is frequently associated with disruption in one's quality of life. Many individuals with mental illness experience inertia; anhedonia; isolation/exclusion; apathy; lack of energy; low levels of motivation; and general dysfunction in daily living. Mental illness can affect one's thinking, mood and/or behavior and can be associated with impairment of functioning, however, the severity and experience of symptoms vary with each individual (American Psychiatric Association, 2013; Centre for Mental Health and Addictions, 2009; Davidson, 2003; Shatkin, 2015).

Wu, Wu, Liao, Chang, and I-Chen (2009) examined coping strategies of individuals hospitalized with mental illness. Along with illness-related symptoms, the challenges identified included "separation from family and/or friends, loss of key roles, diminished self-image and self-esteem, loss of autonomy, weakened support networks, unpredictable futures, and increased anxiety and resentment" (p.24). Gibson-Cline (1996) and Frydenberg (2008) echo much the same sentiments in their evaluation and recommendations for adolescent coping, emphasizing the value of relationship and healthy connections in overcoming adversity. This notion is particularly problematic with regards to adolescent mental health, as I have previously identified peer relationships, identity, autonomy, and planning for one's future as central tenets of adolescent development (Kleiber, 1999; Shatkin, 2015; Steinberg, 2017; 2020).

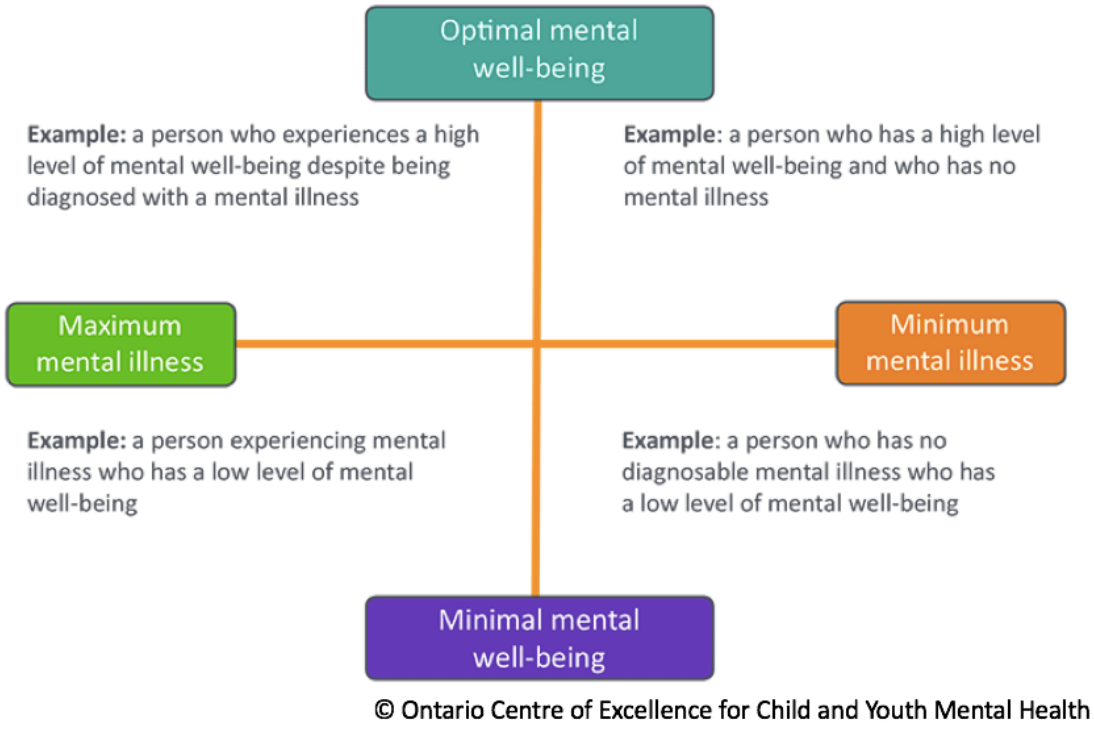
Governments often discuss mental illness in terms of financial expenditure and allocation of resources within budgets. However, literature supports the consequences of mental illness as they extend beyond the health care system and transcend all aspects of one's life, creating challenges that may include unemployment, underemployment, low social economic status, increased isolation, increased boredom, self-medication and an overall lack of satisfaction with everyday life (Drake, Bond, Thornicroft, Knapp, & Goldman, 2012; Government of Canada, 2006; Health Canada, 2002). Davidson et al. (2009) suggest that the onset of mental illness is associated with a sense of loss of one's self across a variety of domains. It may be reasonable to suggest even greater consequences among the adolescent population as persistent mental health issues pose a significant barrier to development and thus prevent the acquisition of skills and capacities that are necessary for independent functioning in subsequent lifestages. Shatkin (2015) reports that adolescent mental health is a dramatically underserved area of research and service in Canada (and the USA) and emphasizes the need for further exploration. As such, this section will begin to explore the following questions: *Are some of the needs that teens have thwarted in the face of mental health challenges, and if so, what is the consequence of this?* Moreover, *how does mental illness change or affect the developmental process?*

Recovery

Recovery is positively correlated with mental health. As previously stated, I believe positive mental health is a state of well-being in which an individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to her or his community. Mental health includes one's emotional, psychological, and social domains. It affects how one thinks, feels, and acts. It is a predictor of our ability to handle stress, relate to others, and make positive choices. Mental health is the encompassment of physical, mental and social well-being and not merely the absence of disease

or infirmity. As such, within this section, it is reasonable to suggest that although the notion of recovery is associated with mental illness, this discussion is equally translatable to individuals who are struggling with mental health issues that have not been otherwise specified. As previously discussed, there is an intersection that exists between mental health and mental illness; just as it is possible to have poor mental health without the presence of formal illness, it is equally possible to have good mental health but live with a mental illness. As illustrated in figure 2.1, both mental health and mental illness exist on continuum that ranges from psychological dysfunction to flourishing.

Figure 2.1 – Continuum of Mental Illness and Mental Well-Being



The following discussion of recovery from mental illness is presented in congruence with current literature but extends these concepts to individuals who demonstrate risk factors for and/or symptoms of psychopathology without formal diagnosis (Shatkin, 2015).

"Recovery is endorsed not as a medically mediated concept but rather as an ongoing process involving the regaining of a valued role and selfhood in society" (Moran & Russo-Netzer, 2016, p.273). Recovery from mental illness involves a reduction in clinical symptoms and the establishment (and control over) a life that is personally satisfying. There are both clinical and social issues associated with mental illness (inertia, anhedonia; isolation/exclusion; apathy; lack of energy; low levels of motivation; and general dysfunction in daily living) and recovery involves a process that must first address the biological, then the psychological and lastly the social processes of living (Anthony, 1993; Andresen et al., 2011; Calabrese & Corrigan, 2005; Davidson & Roe, 2007; Greenblatt, 1957; Jacobson & Greenly, 2001; Slade, Oades, & Jarden, 2017).

The essence of recovery is to re-establish a new and valued sense of integrity and purpose within and beyond the limits of the disability or illness. There are five guiding principles that have informed my exploration of recovery, as thematically supported by the current body of recovery literature: (1) an understanding of recovery can only be defined through client-lived experiences; (2) recovery is a process rather than an end result or product; (3) recovery is a lifelong commitment for individuals with mental illness, that involves an indefinite number of incremental steps in various life domains; (4) recovery is not synonymous with cure, nor is it a return to a premorbid state; (5) recovery is most successfully navigated when strategies are adopted as a new way of life, rather than as a temporary solution. Moreover, in a brief meta-analysis for my comprehensive examinations I identified nine common themes represented across the recovery literature: i) redefining sense of self, ii) renewing a sense of hope and commitment, iii) accepting illness, iv) being involved in meaningful activities and having expanded social roles, v) managing symptoms, vi) resuming control over and responsibility for

one's life, vii) overcoming stigma, viii) exercising citizenship/sense of agency, and ix) experiencing positive emotions and satisfaction as a result of engagement in life activities.

For the purpose of this research, I will reserve my exploration of recovery to the aspects that relate to leisure engagement. Within this framework I will discuss acceptance, hope, identity, pleasurable life events, agency/autonomy, and social connections/engagement as tenets of the recovery process and connect each to the current literature regarding adolescent development and/or mental health. Further, I extend the notion of recovery in the adolescent life stage to be regarded as a journey of self-development that encompasses complex characteristics of change for individuals living with mental illness and/or struggling with mental health, rather than as a clinically mediated process.

Cripps-Torok (2014) explored the process of recovery with co-researchers and proposed it to be a multi-faceted, non-linear process that supports the development of skills and capacities deemed to be necessary for an individual to live well with mental illness. It was suggested that recovery has both personal and clinical dimensions, often initiated by pharmacological intervention in an effort to reduce the clinical (biological) symptoms associated with the illness. Once clinical symptoms are managed, the second step to recovery involves the establishment of internal conditions that will support the individual's external sustainability. These conditions are inclusive of an individual's sense of identity, hope, healing, empowerment, and connection. Following the attainment of necessary internal conditions, the final stage involves community reintegration and the establishment of external networks that support the individual's strengths and capacities, as well as interests, and allow them to connect to a dominant narrative that is personally meaningful. It seems possible that the recovery process could be more innate in the adolescent population, as it aligns well with the developmental processes outlined in my previous section.

Recovery is a highly unique process that is different for each person and therefore there is no universal formula that will yield particular results, but there may be a set of "ingredients" that individuals can combine in varying quantities to create their own masterpiece. To me, recovery regardless of the life stage, involves a personal commitment to change, implemented through a series of choices that involve a daily commitment to resolving conflicts across the biological, psychological and social domains in everyday life. This process most often requires one to make changes that are often in contrast to their current habits. Such changes require purposeful engagement in new behaviours that often reside well outside of one's repertoire and therefore feel unfamiliar, challenging and often exhaustive of one's physical and emotional resources. Recovery could therefore be described as a commitment to self-development and a shift in self-care that yields the possibility of life that is rich with meaning and purpose that supports one's identity to include mental health challenges but not be defined by them. Within this context it seems reasonable to suggest that the fluidity of the adolescent brain might be more receptive to implementing necessary changes, as thinking and behaving are not yet concrete. If so, then the challenge with the adolescent population in this regard would be associated with treatment-engagement, making programme design of particular importance in this regard.

Acceptance

Acceptance in recovery refers to one's ability to assent to the reality of their illness without attempting to change or protest it. Acceptance is not about submission to the challenges that inevitably come with mental illness but rather a purposeful choice to embrace that which cannot be changed, as a means of creating space to envision and move towards one's desired life (Hayes, Strosahl, & Wilson, 1999; Harris, 2009).

Acceptance–which we use interchangeably with allowing –refers to the ability to allow unwanted private events or behaviour (thoughts, feelings, physical sensations, memories,

> urges, and so on), to simply let them be present until they pass rather than trying to push them away, push them down, or avoid doing things that bring them up. (Turrell, Bell, & Wilson, 2016, p.33)

Turrell and colleagues (2016) suggest that individuals most often initiate relationships with helping professionals after having exhausted their efforts attempting to solve the unwanted thoughts and feelings that are getting in the way of their desired outcome (life goal).

Central to a life well lived is one's ability to accept the challenges associated with the acquisition of illness and/or disability and central to acceptance is letting go of our innate desire to "get rid of the things we can't get rid of" (Turrell et al., 2016, p.13). Acceptance, in this context, allows space for challenge while relieving the need to change what has happened (illness) and to redirect the relationship one has with said challenge. By externalizing the illness from personhood, we can change the relationship an individual has with their illness and explore greater opportunity for personal development. Hayes, Pistorello and Levin (2012) echo much the same suggesting that regardless of the origin of dysfunction, acceptance is central to moving towards one's desired goal (a better life).

It seems reasonable to suggest that acceptance creates a foundation for the recovery process. Acceptance is associated with truth about oneself and creates space for self-compassion and subsequently the exploration and development of one's best self. Acceptance of one's illness allows the opportunity to foster hope and optimism for the future, to explore and establish a positive identity, to develop a sense of agency, to experience pleasure, and to establish meaningful social connections, all previously discussed as elements of recovery. Although indeed, recovery is an ongoing process that involves a purposeful relationship with oneself through a well-supported exploration, perhaps acceptance of self and illness is the catalyst to this development.

Hope

Central to the recovery process is hope. Individuals with mental health challenges must find ways of connecting to the possibility of a better life (hope) before they can begin to expend the daily resources necessary to facilitate required change (Andreson et al., 2011; Cripps-Torok, 2014). As such, one must first develop and maintain their hope awareness, in order for the process of recovery to be possible. Jacobson and Greenly (2001) present hope as an internal condition that supports external sustainability. Snyder (2002) suggests that hope is not an emotion but a thinking process that influences how a person feels. Building upon both, it seems possible that hope is a unique process that is central to all aspects of recovery (and living well) as it supports individuals in their commitment to biological, psychological and social change. Equally, Steinberg (2017; 2020) suggests that adolescents who are hopeful about their future roles weather the challenges of this difficult life stage better than those who are not. Shatkin (2015) iterated much the same, specifying in the case of adolescent mental health, that hope is essential to fostering resiliency, which she later identifies as a predictor of sustainability in the face of mental health challenges across the lifespan.

Hope Theory (Synder, 2002) suggests that goals are central to the initiation and maintenance of hope and are inclusive of the ability to plan pathways to desired goals, despite obstacles. Accordingly, when a valued goal is sought, hopeful behaviour demonstrates three qualities: (i) the outcome value, (ii) thoughts about pathways to the goal and realistic expectations for achievement and (iii) personal sense of agency including beliefs in one's effectiveness in accomplishing the goal (Snyder, 2002). More simply stated, hope requires the presence of a goal, the ability to foresee a pathway to achieve the goal, and the trust in one's capacity for success. Interestingly, Shatkin (2015) presents goal setting within the framework for evidence-based treatment approaches for adolescents who are challenged by mental illness.

Lozarus (1999) suggested a fundamental condition of hope is that one's current life circumstance be unsatisfactory. This is a notion that Snyder (2002) later referred to as the "repair" definition, suggesting that goals serve to fill a void in one's life, and therefore, there must be a gap present for one to desire change. Carr (2011) argued that hope is determined by past experiences, so one's ability to connect to hope is somewhat reliant on past successes, and therefore equally challenged by past failures. As such, hope theory compliments the recovery process well in that individuals are seeking the possibility for a better life, but often are challenged or discouraged by previous experiences and therefore ongoing incremental gratifications are necessary for one believe that the possibility of living well is relevant to them.

Hope (as a trait) is primarily developed through infancy, childhood and adolescence, with the highest levels of hope found in individuals who have learned to cope with adversity and to manage challenges adequately, relative to their current life stage (Carr, 2011). Equally, hope (and optimism) are challenged in the absence of acceptance (from self and others), as it is particularly difficult to envision the tangibility of a better life while engaged in a struggle of trying to undo the onset of disability or illness (Harris, 2009).

Children develop hope and resiliency when they are provided with adequate social support to cope with adversity and are firmly attached to their caregivers or parents. Hope continues to evolve through adolescence with the onset of a positive self-identity and increased autonomy. As such, if the sustainability of hope is rooted in past experiences, but if an individual has not had the opportunity for such development, it would be reasonable to suggest this as a starting point in their recovery process. It therefore seems reasonable to suggest that early intervention may challenge the adversity that disrupts the development of hope and leaves adults feeling hopeless and living unwell with mental illness.

Snyder (2002) suggests that hope exists on a continuum. The behavior of setting and achieving goals is dependent on a person's self-efficacy (belief in the ability to succeed) and the skills and capacity possessed to support behaviour. Although an individual must believe that the goal is attainable, if a goal is easily obtained it will not render the development of hope. As such, hope involves experiences that support a balance between challenge and skill, a notion that is relatable to Csikszentmihalyi's (1990) flow theory which will be discussed briefly in subsequent sections. People with low hope need help in developing pathways to achieve their goal. Whereas people with high hope, require much less support in order to successfully achieve a desired goal. Within the recovery framework, this suggests that individuals who are low in hope are likely to require more intensive support in order to establish the skills and capacities necessary to navigate the challenges associated with mental illness more independently. Individuals with low hope require direct pathways to a goal in order to maximize their chances for success. And, such goals should be self-directed as hope is more readily achieved when the individual naturally values the goal, rather than seeking achievement that has been imposed upon them (Snyder, 2002). Equally, this reminds us of the value of individual assessment prior to intervention, as a baseline indicator of where our clients measure in hopefulness to ensure that we support their process of development with adequate resources, including but not limited to TR services.

Hope is positively correlated with optimism as a predictor of mental and physical health. Carr (2011) suggests that optimism, though connected to hope, can be a personality trait with heritable connection and employs the anticipation of positive future outcomes. However, Turrell and colleagues (2016) suggest that optimism can be fostered through a clarification of goals and ongoing opportunities for achievement (Hayes, Strosahl, & Wilson, 1999; Harris, 2009). Clark and colleagues (2012) suggest that hope involves longing for something that may not be certain but is at least possible. Further, hope leads to the conviction that one's future and meaning are

inherently valuable. As such, it may not be far-fetched to suggest that individuals with a naturally optimistic world view will connect more easily to the hope-based thinking and may require much less support in this domain of recovery.

As Snyder (2002) reminds us, people learn to be hopeful and goal oriented in the context of other people, so the loss of hope often has involved other people. Individuals who lack hopefulness may do so as a result of past social experience and/or disruption in their family support network. Simonds, Pons, Stone, Warren and John (2013) echoed this notion and proposed that increasing social interaction through leisure may increase hope for the future, regardless of personality, and may provide a neutral environment in which to develop the skills necessary to establish and maintain healthy social relationships as part of the recovery process. This suggestion may be of particular importance to the adolescent population, as the developmental literature consistently emphasizes the need for peer relationships during this life stage.

Recovery is the process by which people reclaim their life and build their connection with themselves while developing a new sense of meaning and purpose. Without hope there is a loss of anticipation about the future, therefore no belief in the possibility for a more connected future (Bassett, Lloyd & Tse, 2008). Bassett and colleagues (2008) suggest that hope-based interventions restore balance by allowing clients to first generate a sense of hope, regain focused hope specific to the circumstance faced, find meaning and purpose in life, and form a strong sense of self-identity. Furthermore, hope-based interventions work to buffer the negative effects of mental illness such as loss of function, social withdrawal, loss of identity, shame, despair, loss of meaning and purpose, the effects of which remain unbiased to age (Bassett et al., 2008).

Lyubomirsky (2007) suggests that there are six benefits of goal setting and pursuit of those goals (hope): increased autonomy (Cantor, 1990); increased self-esteem (identity) and

experience of positive emotions (Deci & Ryan, 2000); increased time management; increased prioritization of goals; increased socialization; and increased coping skills. In this regard there may be three overlapping phases to living well with mental illness that represent the intersection between hope and the process of recovery that leads to living well. The first phase would represent ambivalence, where individuals are merely contemplating the possibility of a better life (negotiating hope). The second phase would represent an individual's commitment to taking action to attain the life they now consider to be possible (affirmed connection to hope). The final phase would represent the purposeful employment of a particular set of strategies in habitual patterns of behaviour through which individuals support their biological, psychological and social health and describe a life that is meaningful and personally satisfying (maintaining hope). It therefore seems possible that hope is facilitated through acceptance (of self and illness) and is then central to the recovery (and adolescent developmental) process (Cripps-Torok, 2014).

Identity

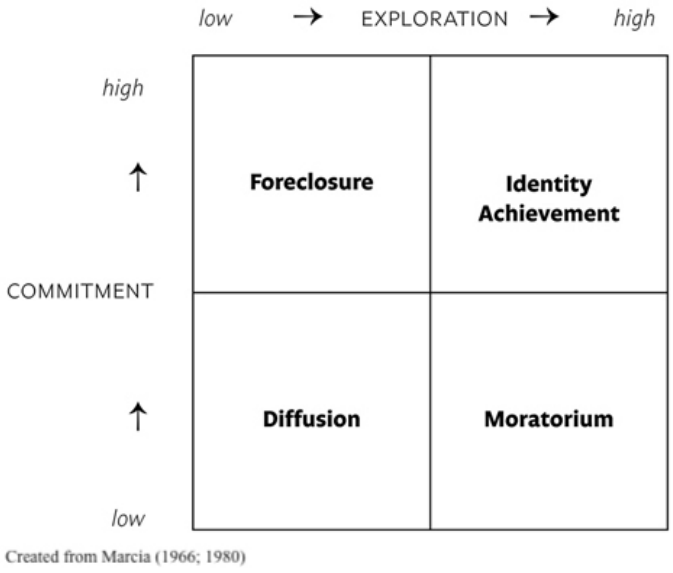
It is particularly important for us to remember that identity development neither starts nor finishes in the adolescent life stage, it is a phenomenon that continues to evolve throughout the lifespan.

> What is important about identity in adolescence, particularly late adolescence, is that this is the first time that physical development, cognitive skills, and social expectations coincide to enable young persons to sort through and synthesize their childhood identifications in order to construct a viable pathway toward their adulthood. (Marcia, 1980, p.160)

Marcia (1966; 1980) elaborated on Erikson's theory of identity development proposing that two key processes (exploration and commitment) lead to four identity statuses in adolescence: (1) identity achievement, (2) foreclosure, (3) identity diffusion and (4) moratorium.

Although Marcia (1966) initially developed these four identity statuses in an effort to explore Erikson's theoretical model, shortly thereafter this work was integrated as part of identity theory within the literature (Adam, 2000; Marcia, 1980). Marcia's (1966) model classifies individuals in terms of the presence or absence of a decision-making period (crisis) relative to the extent of exploration and investment (commitment) one has made, suggesting identity is achieved through the varied experiences as represented by figure 2.2.

Figure 2.2 – Marcia's Quadrants of Identity Exploration



Created from Marcia (1966; 1980)

Marcia (1966; 1980) suggests that identity is achieved by individuals who experience both a high level of commitment and exploration and who are in pursuit of self-chosen engagements. As such, identity achievement is valanced by the opportunities one has to explore their strengths, weaknesses and interests and is the product of the resolved tensions that are associated with this process. Both exploration and commitment are tenants of the leisure experience. Kleiber (1999) refers to the "fourth environment" (leisure) as a space that exists beyond home, work and school, "where adult control is limited and experimentation with

voluntary control is common" (p.26). He suggests that adolescents often seek out the fourth environment to engage with the developmental tasks most often associated with identity because it naturally facilitates space where this is best achieved. Marcia's (1966) intention was to explore the formation of identity through occupation, and in this regard, Marcia's model aligns well with Kleiber's (1999) suggestion that leisure is the space through which adolescents explore and maintain identity, which then supports the pursuit of vocational and education aspirations.

Hood and Carruthers (2007) define leisure as "those experiences that are pleasant in expectation, experience or recollection; intrinsically motivated; optional in nature; autonomous; and engaging. The term leisure thus includes play and recreation activities as well as other less structured meaningful engagements" (p.300). Leisure is therefore a particularly valuable space through which individuals can explore and discover strengths and capacities that support the attainment of their best-self. It therefore seems reasonable to suggest that leisure is equally relevant to the study of living well with mental illness, as it appears to illustrate space for crisis as well as the process through which one explores and achieves a sense of self without suggesting it is a linear pathway.

Knowledge of self includes self-awareness, acceptance, and congruence which are essential elements to the development of resources necessary for recovery (Davidson, Tondora, Staeheli, Lawless, O'Connell, & Rowe, 2009). This involves personal acknowledgement of strengths as well as limitations. Without such knowledge individuals will remain challenged in their ability to engage in authentic leisure, develop goals that reflect personal meaning, or improve on elements of personal limitation (Hood & Carruthers, 2007). Within the development of self-awareness, acceptance and congruence, an individual must be conscious of their personal attributes and capacities, accept their strengths and limitations and be able to express this identity in a variety of contexts including personal, vocational and leisure-based pursuits (Kleiber, 1999).

The employment of an identity defined beyond the limitations of illness or disability is an integral part of living well. Individuals engaged in the recovery process often experience a loss of self-identity, and adolescents have perhaps not yet developed one. Individuals who are struggling with mental health issues or experiencing disability often cling to negative schemas and self-constructs as a result of stigma, previous life experiences, or as a recent adaptation to their illness (Andresen et al., 2011). Individuals living with mental illnesses (or experiencing mental health challenges) often exist in cycles of dysfunction that result in the disruption of psycho-social functioning and have negative impacts on one's identity. As such, the process of recovery requires one to develop the skills and capacities necessary to narrate a life that incorporates the experiences associated with mental health challenges but is defined beyond them. Accordingly, the externalization of mental illness and the acknowledgement of strengths and capacities are essential in the reconstruction of a positive identity (Andresen et al., 2011; Cripps-Torok, 2014; Slade, Oades, & Jarden, 2017).

Andresen and colleagues (2011) suggest three avenues to reconciling one's self with the illness i.) illness can be accepted as part of the self in a spirit of growth (acceptance), ii.) illness can be seen as something that has to be lived with, but is separate from the true self (externalization), iii.) illness can facilitate the opportunity to connect to a sense of purpose in life that brings about new meaning (sense of agency). A fourth avenue to the self/illness connection is a sense of spirituality, which involves the acceptance of present illness as causal for the greater good. Spiritualty involves a belief that the illness has happened for a reason and creates space for one to find peace within their own challenges, while embracing the work required to get well and stay well (Bassett, Lloyd, & Tse, 2008). Externalization of mental illness from self involves a self-narrative that depersonalizes mental illness and places one's diagnosis outside of the self (Tooth, Kalyanasundaram, Glover, & Momenzdah, 2003). This strategy can be supported

through professional guidance or self-taught practice and is often employed as a coping strategy to aid in the acceptance of illness or disability (Bland & Darlington, 2002). This strategy results in language that names one's mental illness as a separate entity from oneself and is helpful in creating a positive identity that includes mental illness but is not defined by it. A sense of agency could involve the use of intentional activities that are motivated by altruism and/or purposeful gratitude (e.g. random acts of kindness) and include being of service to something other than oneself (Hood & Carruthers, 2007). This connection held by meaningful leisure pursuits is often dualistic in nature. During engagement, one is often granted respite from their present mental health challenges, while pre-and-post one is given the opportunity to experience the positive emotions derived from being of service and the opportunity to build an identity that is rooted in helping others (Andresen et al., 2011; Carruthers & Hood, 2007).

A key factor in the establishment of a positive identity is the acknowledgement of one's own strengths and capacities. This acknowledgement involves the exploration of abilities in combination with the recognition of limitations. This requires accountability and is heavily reliant on honesty with oneself and others. The acknowledgement of strengths and capacities provides the opportunity for increased levels of self-esteem and self-efficacy while recognizing areas in one's life in need of improvement. Through this process, individuals foster a stronger sense of self-awareness that is essential to identity development and maintenance (Anderson & Heyne, 2012a; Carruthers & Hood, 2007; Hood & Carruthers, 2007).

Self-esteem is an associated value measure (self-worth) that is derived from one's ratio of successes to opportunities for success as well as current accomplishments to aspirations (Dutton, Roberts, & Bednar, 2010). Rooted in our own assessment of success and potential, the development of self-esteem is initiated in childhood and continues to evolve across the life span (Carr, 2011). When parents are accepting of children's strengths and limitations while

maintaining high but attainable standards, they support the development of high self-esteem. When parents themselves use active problem-solving coping styles, they transfer those skills to their children (Shatkin, 2015). Self-esteem however is also influenced by social relationships outside of the family such as peer groups at school, residential neighbourhoods and community-based leisure activities in particular amongst the adolescent population as they detach from the nuclear family unit and explore connections with others (Carr, 2011; Kleiber, 1999; Steinberg, 2017; 2020).

Self-efficacy refers to beliefs that we hold about our capacity to successfully organize and perform tasks in our lives. Efficacy beliefs influence many of the choices we make, as we tend to pursue actions with predicable success and have little incentive to pursue actions that we believe will result in failure. Within our domains of functioning, our beliefs surrounding our own capabilities therefore determine our on-going course of action (Carr, 2011). Self-efficacy is derived from experiences in which goals are achieved through perseverance and overcoming obstacles and adversely effected by solution-focused parenting styles (Shatkin, 2015). Sources of influence include mastery of experiences, vicarious experiences, social persuasion and physical and emotional states. Self-efficacy can be developed or strengthened when individuals watch others achieve their goals through continual effort (Dutton, Roberts, & Bednar, 2010). Individuals with higher self-efficacy show greater cognitive resourcefulness, strategic flexibility and effectiveness in managing their environmental challenges, including but not limited to mental health challenges (Carr, 2011).

Suffering, pain and grief (including negative life events and trauma) are simply part of the human experience, however the impact of such events can be lasting (Ryff & Signer, 2003). Post-traumatic growth (PTG) is a term often used to describe the development of a positive outlook following trauma. It involves a shift in one's personal schema (story of self) from the

challenges faced, to the possibility that life has to offer (Tedeschi & Calhoun, 1996; 2004). In particular, PTG is marked by one's ability to view their challenge of illness/disability/trauma as a gift that led them in a new and valued direction. However, PTG is suggested to be ambiguously linked to resiliency with need for more clarity (Tedeschi, Calhoun, & Cann, 2007). In a study examining adolescents who were directly and indirectly exposed to wartime trauma, Levine, Laufer, Stein, Hamama-Raz, and Solomon (2009) explored the relationship between PTG and resilience, determining an inverse relationship. They put forth the notion that resilient youth (people) are more likely to mitigate the impact of an event and less likely to seek out meaning making activities. In this regard, the findings of Levine and colleagues (2009) further validate the importance of purposeful leisure engagement for youth who are struggling.

Pleasure in Everyday Life

Positive emotion is "the combination of positively valanced physiological and/or psychological experiences (positive affect) coupled with some type of positive evaluative appraisal of the experience" (Carruthers & Hood, 2007, p. 284). Positive emotions are most often associated with feelings where there is a lack of negativity, such that no pain or discomfort is felt. Accordingly, the ten most common positive emotions are: joy, gratitude, serenity, interest, hope, pride, amusement, inspiration, awe and love (Fredrickson, 2009). Lyubomirsky (2001, 2007) uses the term happiness interchangeably with well-being to describe the feelings of joy, contentment, positive affect and having a meaning in life, all of which are synonymous with positive emotion.

Happiness (positive emotion) has been an ongoing discussion across the positive psychology literature and is connected to the employment of intentional activities in everyday life (Lyubomirsky, 2001; 2007). According to Fredrickson (1998; 2001; 2009; 2013) benefits from positive emotions throughout a given day are not expunged by simultaneous negative

events, thus making positive emotion a primary factor in resiliency. In fact, it is through conscious momentary experiences of positive emotion that individuals are able to expand upon thoughts and actions that come into their minds.

Fredrickson (1998; 2001) presents the Broaden and Build theory suggesting that through the ongoing daily experience of positive emotion, individuals build up a protective barrier against adverse life events. Within this framework, Fredrickson (1998; 2001) suggests the more successes an individual has, the more willing they are to take on new challenges in the future. As individuals experience gratifications, their self-efficacy increases, and they become more accepting of opportunities that reside outside of their comfort zone. In turn, this creates an upward spiral that is foundational to a sense of agency that could inspire and support individuals to embrace change and the possibility of a better life. Further, the Broaden and Build theory suggests that it is possible to enhance resiliency through a positive internal dialogue. By increasing creativity through experiences of positive emotion, one can improve momentary thought-action processes; in turn this builds emotional resources, promotes further positive emotion and perpetuates an upward spiral (Fredrickson, 2009).

Fitzpatrick and Stalikas (2008) elaborate on the Broaden and Build Theory relating it specifically to the process of change – a necessary element for clients challenged by mental health issues. They suggest the broadening aspect of Fredrickson's (1998, 2001) theory holds more value than the build and it is through one's awareness of their positive emotion that therapeutic change begins, unconscious coping strategies emerge, and in the case of individuals with mental illness, one's potential to flourish grows.

Gruber and colleagues (2009) examined the impact of positive emotions on individuals with mental illness, highlighting the importance of positive emotion as a means of reducing one's functional impairments and morbidity associated with such disease. However, positive

emotion has been regarded for more than its contribution in reducing impairment, but rather as being central to living well (Lyubomirsky, 2007). Fredrickson (1998; 2001) found that positive moments are most effective when experienced in a 3:1 ratio to negative ones, as this is the threshold that buffers the impact of challenges that inevitably exist in everyday life.

Multidisciplinary research supports the notion that positive emotion is connected to increased levels of physical, emotional and social health. One's capacity for happiness, ability to regulate emotion, self-awareness, self-determination, competence, optimism and sense of meaning are all identified as common resources that influence well-being (Hood & Carruthers, 2007). Interestingly, research has identified that one's capacity for happiness has a degree of genetic dependency. Lyubomirsky (2007) proposes that fifty percent of one's happiness is influenced by genetics, ten percent by life circumstance and forty percent by intentional activity-based engagements. As an individual learns to create opportunities for and acknowledge multiple pleasant events on a daily basis, their capacity for happiness will increase. In addition, savouring such experiences through anticipation and reminiscence along with the active engagement in meaningful activities will also increase one's potential for happiness. Though one may have limited capacity to control life circumstance, and no control over our genetic set point, through the implementation of happiness-based strategies, individuals have the power to increase their happiness levels through engaging in intentional activities.

Lyubomirsky (2007) suggests that active engagement in intentional activities is the simplest way to increase happiness, as it provides opportunities for individuals to connect to positive emotions. In addition, Lyubomirsky (2007) found that intentional activities can support: expressions of gratitude; cultivation of optimism; avoidance of social comparisons; practice of kindness; nurturing of social relationships; development of coping strategies; and opportunities

to experience flow, each of which could support the recovery process and equally support weathering the challenges faced during adolescent years regardless of mental health status.

The experience of positive emotion is foundational to recovery, and yet, one's ability to connect to such emotion is dependent on the capacity to recognize positive experiences in the face of adversity. Richman et al. (2009) examined the causal relationship between mental health and physical health, identifying a direct relationship between positive emotion and physical health. Gruber et al. (2009) examined the impact of positive emotions on individuals with mental illness, highlighting the importance of positive emotion as a means of reducing one's functional impairments and morbidity associated with the disease. Shahar and Davidson (2003) examined the role of positive life events in the recovery process from severe mental illness. They identified that individuals who report a higher number of positive life events also report higher levels of self-esteem, sense of self and overall quality of life. As a result, Davidson et al. (2006) suggest that positive life events produce protective effects on individuals and assist them in dealing with the daily challenges associated with mental illness. It is important to note here that the experience of positive emotion can vary in both quality and quantity. Furthermore, positive emotion can be experienced as past, present or future events (Carruthers & Hood, 2007; Hood & Carruthers; 2007). Thus, even if the current circumstance lacks opportunities for positive emotion, there are strategies that can be used to insert positivity into daily life events. It therefore seems reasonable to recommend that positive emotion offers valuable outcomes and therefore should be considered an essential element in adolescent mental health programming.

Challenges of increasing positive emotion

Negative thoughts and beliefs about one's self are rooted in a negative self-schema. Generally speaking, individuals tend to focus on the negative experiences and stressors in everyday life. The negativity bias refers to the notion that unpleasant events, emotions and

thoughts have a greater effect on the psychological state than do processes that are neutral or positive (Baumeister, Bratslavsky, Finkenaur, & Vohs, 2001). The negativity bias has been explored in many domains from (most predominately) infant development to marriage, attention and learning to decision making and risk-taking behaviours, only to conclude the pessimistic reality that "bad is stronger than good" (Baumeister et al., 2001, p.323). In the human brain, negative information simply receives more processing power and contributes more strongly to conclusions than does positive information. Over the past several decades scholars have searched for answers beyond the simplicity of evolution, but so far have come up short (Vaish, Grossman, & Woodward, 2008). As such, I will avoid the attempt to hypothesize otherwise and iterate what we otherwise know to be "true" about the negativity bias across all living species. Organisms who respond to threat are more likely to survive than those who do not. Over time, the heightened awareness of negative processes has wired the human brain to be as efficient as possible in this regard, and therefore affords more rapid power and memory retention to the threats as a means of self (and species) preservation (Vaish et al., 2008). More eloquently stated, "survival requires urgent attention to possible bad outcome, but is less urgent with regard to good ones" (Baumeister et al., 2001, p.325). Although indeed the negativity bias is simply part of the human condition, it seems particularly detrimental when intersecting mental illness.

Adrian, Guillem, Franz and David (2017) suggest that negative thoughts or views of the self are connected to other self-constructions such as self-perceived moral qualities including sensitivity, caring for others, and being a good person. As such, shifting negative thoughts involves addressing the perception of core identity and values. Interventions focused on the development of a positive identity to increase wellbeing are of particular value to adolescents who are challenged by poor mental health. By providing opportunities for individuals to experience positive thoughts about their self, we can begin to reconstruct the neuropathways that

facilitate negative schemas. Furthermore, by focusing on identifying one's strengths and capacities, we create natural opportunities for the positive identity development that aligns with the values put forth in the recovery process and with positive adolescent development (Gander, Proyer, Ruch & Wyss, 2013; Shatkin, 2015; Steinberg, 2017; 2020).

Agency/Autonomy

Autonomy is a concept that involves the subjective interpretation of independence within a given situation. More specifically, autonomy is based on one's perception of the degree of control they can exercise with regard to choices. Within the context of mental health, autonomy can be augmented or diminished by one's ability and/or opportunity to participate in the goal-setting process. Ryan and Deci (2000, 2001) identify both autonomy and competence as essential human needs through which behaviour is motivated. In the context of mental health, if an individual in unable to connect to their sense of autonomy and competence, they are less likely to engage in positive behaviour that will assist them in living well. Davidson et al. (2006) proposed that positive life experiences promote resilience and adaptation and through play and pleasure individuals with mental illness build up their restorative power, self-efficacy and social agency that contribute directly to an overall sense of well-being.

Self-determination theory (Deci & Ryan, 2000) reminds us that goal setting and attainment are sustained by intrinsic motivation and are linked to increases in the need to learn, explore, and master new skills (Carr, 2011). There is a connection between motivation and determination, which can positively or negatively impact one's sense of self, happiness and well-being. It is therefore essential for individuals with mental health challenges to be given the freedom to make choices to engage in activities that are personally meaningful. Not only can well-chosen free time activities (leisure) support the development of motivation, they also can serve as an effective coping mechanism for stress, a source of positive emotion, support the

development of personal strengths and capacities, and provide the opportunity to develop friendships and social connections, to name a few. Sylvester, Voelkl and Ellis (2001) suggest that freedom is a defining element for leisure. Earlier this paper highlighted autonomy as a driving force for adolescent development. As such, leisure provides the space to support the natural process of adolescence in a way that is authentic and, when well used, it could be equally inclusive of forward movement towards achieving a (self-described) meaningful life.

Social Connections/Engagement

Social resources are capacities related to the development of interpersonal connections. They include communication skills, interpersonal skills, reciprocal relationship skills and social confidence (Hood & Carruthers, 2007). Although leisure presents the opportunity to support the development of social skills and relationships, within the same context there could be participatory limitations to leisure based on the current status of one's social behaviours (Hood & Carruthers, 2007). Within this context, in order to develop social resources an individual must have the established psychological resources necessary to cope with the adversity associated with social interactions with others. Thus, meaningful social engagements are often a later practice in the recovery process. In an adolescent context, however, it is likely that opportunities for social connections and engagement are central to developing and maintaining interest in the treatment process. As such, this focus should be a concurrent theme throughout a pilot program, as healthy peer relationships have been identified as a primary need for the adolescent population (Steinberg, 2017; 2020) and is congruent with other recovery-based mental health literature (Davidson, 2011).

Davidson (2011) examines the journey to recovery within the mental health setting and seeks to identify the role that love (relationships) plays in this process. Within this work he suggests that self-love and the love of others are integral to the recovery process. As individuals

face the reality of a mental health diagnosis, they often lose sight of their sense of self, and therefore self-love. Within this context, an individual who in unable or unwilling to love themselves will continue to struggle in maintaining reciprocal relationships with others. In fact, Davidson (2011) suggests that love offers spirit-nourishing properties that enhance therapeutic relationships. Kleiber (1999) and Hood and Carruthers (2007) agree, both supporting the notion that social resources (through leisure) are an important aspect in the establishment of well-being and therefore must be developed throughout the recovery process for individuals with mental illness. Within the context of adolescent mental health, it seems possible that social challenges could be a marker that indicates a particular need for self-development. If an individual is struggling to connect well with others, perhaps the ideal place to start would then be exploring concepts related to self-compassion in an effort to develop a particular skillset and to facilitate the opportunity to explore one's identity in a more productive manner. The development of self-compassion skills can be supported by one's ability to mirror caring behaviours towards others as individuals described directing compassion towards others as easier than bestowing same upon oneself.

Cripps-Torok (2014) supported the importance of reciprocal relationships with others in the development of a meaningful life. Within this project the co-researchers iterated the importance of valued social roles in volunteer-based positions, suggesting that the opportunity to support others is of some importance for those in the later stages of recovery. As a result, meaningful relationships with family, friends and partners and giving back to the community may be of equal importance in the creation of a meaningful life regardless of the life stage.

Meaningful relationships with family, friends and partners involve the establishment and maintenance of connections that are supportive of one's biological, psychological and emotional health. Positive relationships are supportive of one's emotional health and can provide the

opportunity for individuals to increase their levels of self-compassion, self-awareness and self-esteem. Cripps-Torok (2014) suggests that this process is supported by an individual's ability to be self-aware of the impact that negative relationships have on their ability to stay well. As such, it may be particularly important for adolescents to develop the skills that are necessary to recognize and sever unsupportive relationships or to establish boundaries within such relationships as a means of maintaining their safety and mental health. Moreover, there are three protective factors that contribute to individual resilience; these are personality, family and community. Therefore, there is value to ensuring that adolescents develop the skills required to navigate healthy relationships in order to create an environment that will actively support their journey towards recovery (Shatkin, 2015). In fact, a sense of agency for one's community is associated with increased levels of well-being (Ward & Gannon, 2006).

Ward and Gannon (2006) suggest that wellbeing is active engagement in one's community, Cloninger (2006) proposes that it is self-direction and transcendence and Deci and Ryan (2000) focus on the notion of finding meaning and realizing one's true potential in leading a meaningful life. Giving back to the community involves a sense of agency towards improving the lives of others in some way. In a study with adults, Cripps-Torok (2014) suggested that this effort was rooted in the advocacy for mental health, with a primary focus on normalizing mental illness and problematizing the exaggerated images perpetuated by popular culture. Accordingly, giving back to one's community provides therapeutic opportunities for individuals to relay their experiences and inspire hope in others and explore an identity that includes mental illness but is not defined by it. However, it is worth noting that developing and maintaining a sense of agency is not unique to the mental health population, but rather a strategy for practice promoted by the positive psychology movement as an effective strategy for moving towards a greater sense of well-being (Seligman, 2002).

Much of this discussion seems to have echoed the process of development iterated earlier in the chapter. It seems possible that there is a connection between the natural progression of adolescent development and the process of recovery. Moreover, recovery in this regard might simply be a process that involves revisiting the point at which development was initially compromised and mental health challenges began to evolve. Given that many of the innate needs in the adolescent life stage are often similar to the expressed needs of individuals experiencing mental health challenges, there may be value in exploring the deeper connection that could exist between adults with mental illness and potential challenges they may have faced in their adolescent years. This connection certainly brings forth a number of questions, primarily does addressing mental health at the adolescent level reduce the consequence of mental illness in adulthood? Perhaps, providing adolescents with the opportunity to develop the skills and capacities necessary to connect and to live well may be a strategy to reduce the rate of debilitating illness in adulthood. Although exploring a longitudinal study is out of reach within the context of this project, measuring the benefits of early intervention with adolescents might be worth exploring!

Recovery

Possible Strategies

Steinberg (2017; 2020) names family, peer groups, education and employment/leisure/ media as the vital tenants of adolescence in western culture, each of which enhance and challenge the progression of development. Moreover, he suggests that there are three sets of psychosocial difficulties that adolescents face; (1) drug and alcohol use and abuse, (2) delinquency and (3) depression all of which align with mental health service provision. Shatkin (2015) agrees, echoing that the vast majority of chronic and severe mental illnesses most often have roots in childhood, adolescence and early adulthood and therefore this is a period of time

that is too important to overlook. Therefore, it seems reasonable to suggest that strategies identified as effective for adults could be equally supportive of healthy development amongst youth who are challenged by mental health concerns as developing these habits at an earlier age might support greater levels of sustainability through adulthood, thus reducing the impact of future disability.

Attending to basic necessities focuses on strategies related to the biological maintenance of one's self. There are four core strategies that one must attend to on a daily basis in order to fulfill the biological requirements of physical health (1) adequate sleep, (2) balanced nutrition, (3) daily exercise and (4) treatment compliance. These strategies focus on the value of physical self-care in creating and maintaining the foundation required for living well. Once basic necessities are supported, one must then begin to focus on the psychological aspects of self-developments (and recovery).

Cultivating a sense of self requires a focus on strategies used in caring for the psychological self, in particular identity. It emphasizes the necessity for the development of the following skills: (1) self-compassion, (2) self-awareness, (3) self-esteem, (4) positive identity formation and (5) authenticity. Self-compassion involves the execution of kindness towards self and others while maintaining a non-judgemental, receptive state of mind (Bluth, 2017). Self-awareness is one's ability to connect to personal needs and advocate for themselves in benefit of those needs. Self-esteem is the positive evaluation of one's worth. Positive identity formation involves a sense of connection to core values and beliefs and the recognition of oneself as a separate entity to anyone else. Authenticity involves the incorporation of truthfulness about one's whole self and sincerity towards self and others (Miller & Rollnick, 2013). There is likely counter-reliance among these sub-categories, for example, self-compassion helps to increase self-awareness. In turn, self-awareness informs positive identity formation and authenticity. As

Steinberg (2017; 2020) iterates, adolescents require the opportunity to explore their core beliefs and values and to establish a life that supports such findings. As such, not knowing who one is would challenge one's ability to connect to a particular set of values that inform future life ambitions.

Rewriting the story of self requires a focus on strategies related to caring for the whole self. Within this one must be able to narrate a life that incorporates the mental health challenges but is defined beyond these negative experiences. There are two sub-categories that are particularly relevant to adolescent development: (1) externalization of challenges from self, and (2) the acknowledgement of one's personal strengths and capacities. Externalization of challenges involves one's ability to depersonalize mental health and/or circumstantial challenges, for example, one may struggle with anxiety, but they are not the illness. Acknowledgement of strengths and capacities involves discovery and acceptance of one's abilities and making life choices that support pleasurable experiences and provide opportunities to further explore one's best self. The acknowledgement of strengths and capacities is particularly important in fostering a sense of self-efficacy and recognizing areas in one's life that are in need of improvement.

Nurturing social connections requires a focus on strategies related to caring for the social self. There are two sub-categories to consider: (1) meaningful relationships with family, friends and partners and (2) giving back to the community. Meaningful relationships with family, friends and partners involve the establishment and maintenance of connections that are supportive of one's biological, psychological and emotional health. As such, this process is supported by the ability to be self-aware of the impact that negative relationships are having on one's mental health. Reciprocal relationships with others assist in the development of a meaningful life and provide the opportunity for increased levels of self-compassion, self-awareness and self-esteem. Giving back to the community involves a sense of agency towards something greater than

oneself and was highlighted earlier as a platform for therapeutic opportunities where individuals can relay their experiences, capitalize on their strengths and inspire others.

As previously stated, adolescents with mental health concerns are an under researched, underserviced population (Shatkin, 2014). As such, there is a need to explore the experiences of this unique population in order to better understand ways in which we can best serve them. Indeed, the above strategies hold equal value with regards to positive development, however, for the purpose of this pilot study, it seems reasonable to focus on positive identity development, as identity is central to both adolescent development and recovery. Moreover, a focus on identity development aligns well within the scope of therapeutic recreation practice and, therefore, supports the purpose of the project which is to explore the benefits of therapeutic recreation intervention for the adolescent mental health population. Chapter three will discuss this further and will describe the three-phase project that was employed.

Leisure

Leisure has the potential to be a facet of life within which individuals are best supported in their engagement with a lifestyle that is socially, emotionally and physically healthy and inclusive of community-based networks. It seems possible that leisure, well used, could make a significant contribution to increased levels of mental health and buffer the challenges associated with mental illness. Although leisure and recovery with mental illness have not been particularly well explored amongst leisure scholars, there is certainly literature to support its value following negative life events (Anderson & Heyne, 2012a; Carruthers & Hood 2007; Hood & Carruthers, 2007; 2016; Hutchinson, Bland, & Kleiber, 2008; Hutchinson, Bland, & Kleiber, 2008; Kleiber, 1999; Kleiber, Hutchinson, & Williams, 2002; Kleiber, Reel, & Hutchinson, 2008; Lyubomirsky, 2007; Lyubomirsky & Layous, 2013). Given the complexity of mental health as previously outlined, it seems reasonable to suggest that there is no single solution to the challenges that

adolescents face but, rather, that leisure, when well used, could be a vehicle through which we begin to address their particular challenges on a more individualized basis, as supported by best practices of therapeutic recreation (Anderson & Heyne, 2012b). Leisure is central to the development of hope, identity, pleasure in everyday life, agency/autonomy and social connections.

According to Hood and Carruthers (2007; 2013; 2015), leisure provides a setting within which individuals have the freedom to choose activities that are personally significant and that help them to ascribe meaning to their lives. However, in order for leisure to enhance one's well-being, leisure choices and practices must be physically, socially, cognitively or emotionally engaging. The Leisure and Well-Being Model of therapeutic recreation (Carruthers & Hood, 2007; Hood & Carruthers, 2007; 2013; 2016) identifies additional literature to support leisure as an effective coping mechanism for stress management, a source of positive emotion, supportive of the development of personal strengths and capacities, and an opportunity to develop friendships and social connections. This section will explore ways in which leisure could mediate the challenges that exists between mental health and adolescent development, questioning *is leisure a bridge?*

Anderson and Heyne (2012b) distilled the leisure literature and identified seven characteristics that connect leisure to well-being. Leisure is: (1) pleasurable in expectation, experience or recollection; When an individual engages in an activity that is freely chosen, they rarely do so with the intention of reaping negative experiences. This is not to say that leisure cannot generate negative emotions, but to suggest the intention behind the engagement is rooted in pleasure and therefore associated with the greatest possibility for positive emotion.

Leisure is (2) engaging; leisure is absorbing by nature. Generally speaking, when one chooses to engage in leisure, they do so purposefully, which creates the greatest possibility for

the active employment of one's skills and capacities. This is not to say that we are always fully present in a flow like state with every leisure activity, nor to suggest that we are always capable of leaving our stressors behind while participating. Rather, the choice to participate generates greater opportunity to be focused on the activity as providing pleasurable experiences are more often engaging than not (Anderson & Heyne, 2012a). Hood and Carruthers (2007) suggest that leisure gratifications (opportunities for flow-like experiences) contribute to leisure satisfaction and well-being. When we participate in leisure experiences that support a sense of escape from our current state, we develop the ability to cope with challenges in positive ways. As such, these opportunities may be particularly important for individuals with mental illness in that they could provide opportunities for unique escape from chronic symptoms and highlight an individual's strengths and capacities allowing them to develop a heightened sense of competence that exists beyond the limitations of the challenges associated with their daily living (Kleiber, 1999).

Leisure highlights our (3) competence; leisure allows us space to explore our abilities at any level and to further develop skills in accordance with our own desire to do so. It seems reasonable to suggest that people choose to do things that come easily to them, and by nature highlight their strengths, even if it is not a conscious decision. The quality of a leisure experience can vary based on commitment and level of engagement (to name a few) however, there is still benefit held in making the conscious decision to participate. Whether one's engagement is for self-development in an effort to "fix" something, or a pleasurable opportunity to create something for a hobby that in-turn is sold off or gifted, ongoing purposeful engagement that highlights one's competencies certainly has valued outcomes that are supportive of living well (Anderson & Heyne, 2012b).

Leisure is (4) motivating; leisure is participant driven and chosen for meaningful qualities of the experience. Leisure exists on a continuum with intrinsic and extrinsic benefits always at

play. This allows reason for engagement to remain fluid between experiences. At times, one's participation may be intrinsically motivated and focused on the pleasure derived from the activity itself, or a sense of escape from everyday life. However, the same activity in a different context might also involve commitment to others and a sense of obligation that prolongs one's commitment when interest levels have fallen.

Leisure is (5) Optional in nature; leisure is arguably the only domain of life in which we have the ability to choose when and if we will participate, how we will do so, and what we will do. When someone engages in a leisure activity the only temporal constraints that exist are governed by the activities of daily living that exist outside of one's free time (work, family, children, etc.). As such, we have the power to decide when and if we will participate and for how long. Of particular value in this regard, is our ability to resume a creation that is incomplete (as we could in artistic or literary pursuits), or complete the task and move on to another phase, but in doing so we still have the ability to choose the context for engagement (Anderson & Heyne, 2012b).

Leisure is (6) Autonomous; leisure is arguably the only space in life where we have the ability to decide and control what we do. And lastly, leisure promotes (7) Freedom; central to the leisure experience is the notion that engagement has been freely chosen. As such, not only does leisure help to instill a sense of control over one's life, it also provides us with a safe space for developing decision making skills based on our skills and capacities, interests, desires and life goals (Anderson & Heyne, 2012b).

Hutchinson, Bland and Kleibler (2008) suggest that leisure-based coping is reliant on the following: i) learning the benefits of leisure, ii) development of a leisure-coping repertoire, and iii) building personal and social leisure-coping resources. The development of coping skills supports the reconstruction of one's identity and assists in buffering the stress associated with

chronic mental illness. If individuals can learn to utilize a variety of leisure engagements as a means of coping with the challenges associated with mental illness, they can begin to form an identity rooted in pleasurable pursuits that works to distract them from chronic symptoms and to highlight the strengths and capacities they possess. In the context of coping, leisure (well-used) can create distraction from a stressor, can facilitate social support and a sense of belonging with a particular community and generate feelings of positive emotion, which can be experienced as anticipation, enjoyment and reminiscence (Hood & Carruthers, 2012). Just as pharmacological interventions work to treat biological symptoms, meaningful leisure engagements work to address the social and emotional consequences of chronic mental illness. Although the majority of leisure-based research in the context of mental health is focused on the adult population, Kleiber (1999) supports the therapeutic benefit that leisure holds for the adolescent population, suggesting that it fosters opportunity for one to explore the self in a space that is much less obligatory and therefore encourages authentic development.

Iwasaki et al. (2014) found that active engagement in leisure significantly reduced boredom and improved meaning and they therefore concluded that level of leisure engagement is a predictor of recovery. It seems reasonable that a reduction of boredom through increased leisure engagement is particularly important for adolescents as creating opportunity for heightened engagement may serve to reduce rates of drug and alcohol use and abuse, delinquency and depression among this population. Spaeth, Weichold and Silbereisen (2015) agree, suggesting that depression is decreased when boredom is reduced, particularly through positive social connections with peers. The onset of disability tends to support an overabundance of free time as unmanaged mental illness often leads to a disruption in social and/or vocational relationships.

Cripps-Torok (2014) proposed four primary functions of leisure in recovery and living well with mental illness. (1) The power of leisure in activation; leisure provides the opportunity for individuals to engage in an active lifestyle that supports the regulation of physical and emotional health and assists in the reduction of sedentary behaviours. (2) The power of leisure in resiliency; leisure provides meaningful experiences that support increased levels of positive emotion and build up a restorative power that assists in buffering the negative symptoms associated with chronic mental illness. (3) The power of leisure in authenticity; leisure provides safe opportunities for individuals to explore, express, establish and maintain a multifaceted identity that is connected to one's best-self and allows space for the self-acceptance, care and compassion that are central to living well. (4) The power of leisure in reducing struggle; leisure most often exists in a space that highlights one's best self and gives individuals reason to get well, stay well and, as a result, becomes central to the process of recovery from and living well with mental illness.

Iwasaki, Coyle, and Shank (2010) examined the potential contribution that meaningful leisure experiences have on active living, recovery, health and quality of life for individuals with mental illness. Within this work, they found that leisure creates a sense of normalcy, the opportunity to cope and heal, a sense of identity and opportunities for positive emotions and social connectedness. Frank and Davidson (2012) examined the self-esteem-based experiences of individuals diagnosed with psychosis as a means of understanding how individuals with mental illness experience self-esteem. They concluded that individuals with mental illness maintain a higher sense of self by pursuing social and interpersonal activities that enhance their physical selves and support a positive body image. Accordingly, it is through leisure activities that adolescents could assume opportunities for self-development that don't otherwise exist.

Caldwell (2005) examined the therapeutic benefits of leisure and found that leisure activities buffered the impact of negative life events and created context for prevention, coping and transcendence, further suggesting that mental health can be influenced positively by leisure engagements - a notion that is arguably fundamental to weathering the inevitable challenges faced by adolescents. Fullagar (2008) examined leisure as a counter-depressant aid in assisting women in their recovery from depression and identified leisure as an opportunity for identity transformation, personal expression and creativity as well as a modality for increased self-care, concluding that leisure can facilitate recovery in ways that biomedical treatments cannot. These findings are well supported by additional scholars who have examined the positive role of leisure in coping, identity development, personal expression and well-being (Dutton, Roberts & Bednar, 2010; Hutchinson, Bland, Kleiber, 2008; Hutchinson, Loy, Kleiber & Datillo, 2003; Hood & Carruthers, 2002; Kleiber, 1999).

Therapeutic Recreation

Therapeutic recreation (TR) is an allied health profession that focuses on choices and engagement in one's discretionary time. TR service is particularly useful for supporting individuals in the pursuit of leisure engagements that are personally satisfying and compliment one's strengths and capacities. The purpose of the field is to enhance individuals' ability to engage in meaningful, freely chosen leisure activities that increase outcomes such as positivity, autonomy, optimism and social engagement, to name a few. As such, therapeutic recreation services will be the vehicle for program delivery for this project, providing action-based opportunities for adolescents to engage in TR programming that they otherwise would not have access to. This study utilized purposeful TR interventions that translated the factors and practices from previous research findings, that best aligned with the natural progression of adolescence,

and that supported the development of the capacities deemed necessary to navigate mental health challenges experienced within this life stage.

The role of the recreation therapist is to assist clients in the establishment of goals that are both measurable and attainable in an effort to structure the process of change in a way that is accessible for clients. Practitioners create a dialogue with their clients that provides the opportunity for connectedness and allows clients to feel understood in their current circumstance. By doing this, they create safe and inclusive environments that include activities that are personally meaningful and provide clients with the opportunity to establish behaviours that support the discovery of one's best self. Within this context, it is possible that leisure, well used, could provide similar experiences for clients beyond the confines of any treatment program, extending the value of TR service well beyond the immediate state.

As discussed previously, Cripps-Torok (2014) examined the experience of mental illness and recovery in an effort to understand the factors that support living well and the strategies supported by the findings were discussed at the beginning of this section. This focus was congruent with the professional aims of therapeutic recreation and informed the present research. It seems possible that we create great opportunity for development through the engagement in leisure activities that capitalize on our strengths and generate meaningful experiences that, in turn, contribute to the cultivation of our best self. As such, therapeutic recreation holds particular value for individuals experiencing mental health challenges, as it allows the opportunity for one to explore and express aspects of themselves that exist outside of the challenge and shifts one's focus back to what is already working.

The employment of therapeutic recreation practice in the context of adolescent mental health could work to support the psychological, emotional and social development of those who are challenged by mental health concerns. Through the facilitation of services that connect

individuals to activities that are personally gratifying, TR services could promote internal desires for change and generate the opportunity for youth to connect to a sense of optimism about their future.

Through the support of the Leisure and Well-Being Model of therapeutic recreation, a pilot therapeutic recreation program focused on increasing strengths awareness within the adolescent mental health therapeutic setting as means of facilitating positive self-narrative (Carruthers & Hood, 2007; Davidson et al., 2006; Hood & Carruthers, 2007; 2013, 2016b) was developed and evaluated. Central to strengths-based practice is the process of helping clients to identify personal aspirations, set related goals, mobilize strengths towards the attainment of such goals, encourage autonomy and facilitate opportunities for clients to engage with the TR process, all of which have been discussed earlier in the context of adolescent development.

Be Your Best Self Program

The "Be Your Best Self" program (BYBS) (Hood & Carruthers, 2016b) is a therapeutic recreation program developed in 2013 with the goal of developing a strengths-based identity for people with mental illnesses. The BYBS (adult) program focuses on topics such as knowing and using strengths, sense of self, recognizing hope and personal empowerment. The original BYBS program was designed for the adult population as a closed 12-week group, 1.5 hours a week, was first implemented in 2013 and has been running since that time in outpatient mental health services at a local hospital. There is anecdotal evidence of the value of this program to clients with formal research on the program being conducted concurrently with this project. The next chapter will provide an overview of the research process used in this study, including how the Be Your Best Self-Youth program was developed (using an evidence-informed approach), implemented and evaluated.

Chapter 3 – Research Methods

This project is a qualitative, interpretative phenomenological study that was guided by the evidenced-informed process as a framework for program design, implementation and evaluation. Using multi-method data collection, this project was been broken down into three phases which will be individually discussed. The purpose of this study was to critically explore mental health as it pertains to youth through the evaluation of a therapeutic recreation intervention. The content and process of the program were informed by youth voice, by adopting a strength's perspective and integrating purposeful facilitation techniques this research challenged the norms of treatment services as described by the youth participants in phase one. This study is situated in an interpretive paradigm while using an evidence informed process for program development. The evidence-informed framework informed the development of the Be Your Best Self – Youth (BYBS-Y) program, while a phenomenological approach was used to examine the perceived outcomes of such. The subsequent pages of this chapter will narrate the methodological approach of this project, epistemology, role of the researcher and the various methods employed in each of the three phases of this project.

Methodological Approach

This project was community engaged research informed by a combination of theory and pragmatics associated with working in and with an agency. Through the employment of a three-phase process, a twelve-session evidence-based program (Hood & Carruthers, 2016b) was translated into an eight-session evidence-informed program designed to support adolescents living with mental illness. This project was a qualitative, interpretive, phenomenological study that incorporated some complimentary quantitative measures in phases two and three. This project blends two perspectives on developing and evaluating interventions. First, the project is firmly situated in an interpretive phenomenological framework. In brief, this framework views

reality as a subjective construction of the individual and suggests that it is important to understand individuals' perceptions in order to better understand their experiences. The second element of the project is evidence informed practice, which is a particular approach to developing interventions.

This project was broken down into three phases and aligns with Drake and colleagues' (2005) recommendation for engaging stakeholders in effective program development in mental health practice. In phase one, a focus group was conducted with five youth accessing residential treatment services in an effort to better understand the needs of the population. This phase represented the consumer voice process of evidence-informed practice (EIP). In phase two, feedback on the program was collected from therapeutic recreation practitioners employed in adolescent mental health. This phase represented the clinical expertise of EIP. Finally, in phase three both qualitative and quantitative measures were employed to evaluate the effectiveness of the program with formative feedback collected through social validation scales and summative feedback collected through pre- and post-program assessment scores and a participant focus group.

Given the inductive nature of this project, the evidenced-informed process guided the division of each phase. Qualitative data collected in phases one and three were the primary focus of the study, the data generated from phase two provided validation regarding the structure and focus of the program but did not inform any changes made prior to the pilot evaluation. The data were collected through the use of focus groups, and program materials (written exercises), written feedback responses and fieldnotes served to provide the greatest insights regarding the program evaluation. In addition, complimentary quantitative data were collected in phases two and three and descriptive statistics were utilized to enhance the qualitative results. The quantitative data were collected by means of surveys for participants and practitioner feedback as

well as standardized assessment instruments for pre- and post-program testing intended to measure participant change across several categories. The specific details of such are outlined in chapters four, five and six (results).

Drake and colleagues (2005) suggest that there are three primary stake holders in effective mental health program development: (1) Consumer voice that represents both needs and preferences; (2) Clinical expertise; and (3) Evidence-based and best practice for the particular discipline. Evidenced-based practice is a rigorous approach to service that is based solely on research to guide predictable client outcomes (Drake, Merrens, & Lynde, 2005). While evidence-based work is of high value, it purposefully excludes the variability factors associated with professional expertise and recipient voice with the intention of yielding the highest degree of reliability. As discussed in chapter two, youth value and seek-out autonomous pursuits, as having a sense of control over one's own life and identity is a benchmark of this life stage. As such, the evidence informed process aligns well with the adolescent population as it is guided by research evidence and professional experience while also placing high value on client voice. Evidence informed practice reflects a purposeful shift from prescriptive to collaborative interventions, which is particularly important when trying to motivate and assist recipients to internalize wellness-based curricula. While evidence informed practice is still rooted in best practices, it illuminates the value of all three stakeholders outlined above (client, practitioner expertise and literature) creating more adaptability for interventions based on the voiced needs and interests of the recipients than does evidence-based practice.

Evidence Informed Practice

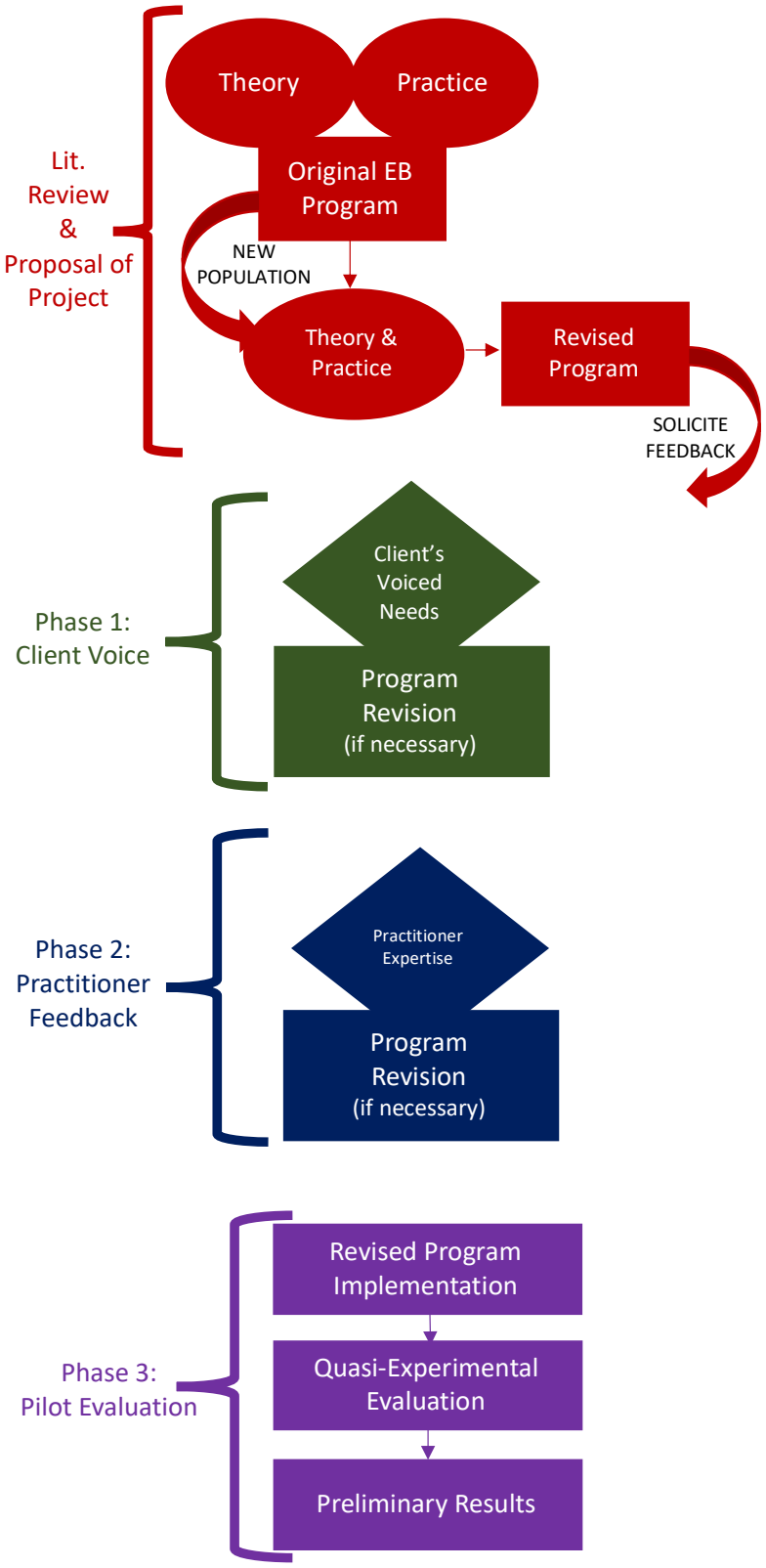
Evidence informed practice is a patient centred approach to health-related interventions that involves the purposeful integration of research evidence, clinical expertise and client values to guide informed health care decisions (Cordingley, 2008; Nevo & Slonim-Nevo, 2011; Rycroft-Malone, 2008). Evidence informed practice places high value on client voice while integrating clinical expertise guided by research evidence and professional experience. Evidence informed practice is underpinned by the acknowledgement that what works in one context may not be appropriate or feasible in another, and therefore aligns well with a community-integrated research project (Ontario Centre Of Excellence for Child and Youth Mental Health, 2019). Evidence informed practice reflects a purposeful shift from prescriptive treatment to collaborative intervention. While it is still rooted in best practices for a particular discipline, it illuminates the value of all three stakeholders, creating more adaptability for interventions based on client voice than does evidence-based practice (Nevo & Slonim-Nevo, 2011).

This project employed a seven-step process that shared connection to the evidence-informed and evidence-based literature: (1) the problem was identified (youth struggling with mental health challenges); (2) evidence was collected through literature review (research), client voice and clinical expertise; (3) the evidence was critically appraised (4) the Be Your Best Self-Youth (BYBS-Y) program was developed; (5) The BYBS-Y program was implemented with pre-and-post measures; (6) the impact of the BYBS-Y program was evaluated; (7) Results of the BYBS-Y program were disseminated.

Be Your Best Self (Hood & Carruthers, 2016b) is a pre-existing therapeutic recreation program created with the goal of developing a strengths-based identity for people with mental illnesses. The program was first implemented in 2013 and has been running since that time in outpatient mental health services at a local hospital. There is anecdotal evidence of the value of

this program to clients with formal research being conducted on the program concurrent with this project. In this project, the BYBS program was adapted for implementation with the youth mental health population and piloted in residential treatment services. The changes to the pre-existing program were informed by the phase one focus group, the design changes and topical areas were then validated by the practitioner feedback obtained in phase two, and finally the adapted program was piloted in phase three with formative feedback obtained through social validation scales, and summative feedback though the employment of pre and post standardized measures and a post-program focus group. Figure 3.1 is a visual representation of the evidence-informed process employed through a three-phase design.

Figure 3.1 – Evidence-Informed Process



Central research question

How might a therapeutic recreation intervention designed to [broadly] support the development of a positive personal narrative impact adolescents' perceptions of living well with mental illness?

Epistemology

At the start of my graduate student career I sought to examine how individuals with mental illnesses construct and make meanings of their own realities in an effort to fill a gap in my own curiosity and in the current literature. Within this context, I wanted to gain insight into how individuals view their experiences of mental illness and subsequently build a meaningful life outside of this identity and learn to live well. As such, I aligned myself most comfortably with the interpretivist paradigm in research as I believed it created a transactional space for exploration where a reciprocal relationship could exist between my lived experiences and those of my co-researchers.

I believe that reality is a self-constructed product of one's social interactions and the meanings they ascribe from their own interpretation, and, that truth is not absolute, but rather a product of human judgment (Angen, 2000; Black, 2006; Creswell, 2003; 2013; Ferguson, 1993). Accordingly, my research continues to be rooted in two assumptions of the interpretivist paradigm. First, reality is constructed within the individual and meanings are developed socially. Second, one cannot separate oneself from what they know and there is a reciprocal relationship between the self and the world we live in. In other words, how we understand the world is central to how we understand ourselves and equally, how we understand ourselves is influenced by the world in which we live in (Angen, 2000; Black, 2006; Creswell, 2003; 2013).

Jones, Torres and Arminio (2014) suggest that there are similarities among

constructionism, constructivism and interpretivism in that all three paradigms are associated with an understanding of meaning making. However, each differs in focus. Constructionism highlights "how meaning is derived through social collective processes" (p.17) and tends to employ a critical lens to meanings that allows for the consideration of unspoken assumptions. Constructivism highlights "how individuals learn and make meaning linking new knowledge to existing understanding" (p.17) while detaching from critical analysis and emphasizing the individuality of unique experiences. Finally, interpretivism "seeks to take participants and researchers to a deeper understanding of a phenomenon by uncovering aspects that have been hidden" (p.17). Interpretivism therefore emphasizes the individual within the experience, recognizing there is a bidirectional relationship that exists between the social influences/social world that impacts the construction of meanings and the individual who creates them (Angen, 2000; Black, 2006; Creswell, 2003; 2013; Ferguson, 1993; Jones et al. 2014).

Green and Thorogood (2014) suggest that, in health research, different epistemological approaches simply represent different ways of knowing. Moreover, an interpretivist approach in health research aims to understand human behaviour rather than to explain it. This approach is not focused on reality itself, but rather on people's interpretations of it. Thus the "interpretive tradition characterizes much qualitative work in health research [and] focuses on the meaning of the phenomena for people" (Green & Thorogood, 2014, p.14). For the purpose of this doctoral project, I align myself with the interpretivist paradigm as defined by Green and Thorogood (2014) borrowing tenants of action research that further support the sense of agency associated with inspiring institutional change in the mental health arena.

Role of the Researcher

As an individual living well with mental illness, my story remains central to the

inspiration for my program of research. Although I have integrated my view on my role as the researcher throughout this paper, I feel it is important to briefly discuss what it might mean for the work I do, and for those who participate. To me, the interpretivist framework supports that reality is constructed through individual perceptions, and therefore the role of the researcher is to connect to the subjectivity of an individual's experience in order to understand the ways in which one's knowledge is constructed. Within the context of qualitative research, this involves the opportunity to engage with individuals under real-world conditions, allowing the opportunity for open dialogue. As an interpretivist researcher, I believe my work is co-constructed and therefore I employ co-researchers rather than participants. For me, there is an ongoing negotiation with my co-researchers in the construction of new knowledge and we work together to get there. Within this idea, I seek a holistic approach to the understanding of their experiences in living with mental illness, which I will explore in the first phase of my project (Angen, 2000; Black, 2006; Creswell, 2003; 2013; Ferguson, 1993; Jones et al. 2014).

As an interpretivist researcher, I believe that reality is a social construction of our experiences that remains fluid and is therefore temporal and constantly evolving. Within this context, my role as a researcher is to disseminate the knowledge as it relates to each of the research questions I ask. As I think critically about the power relations that exist between researcher and participant, I acknowledge that there are challenges associated with my age and life stage, with my ties to an academic institution; with possible differences in worldviews; and, of course, with our (likely vastly) differing life experiences. Interestingly, within my master's thesis I discovered my co-researchers also had embedded assumptions about my role as the researcher. Although indeed I took on the role of the academic expert who was ultimately responsible for the dissemination of knowledge, my co-researchers were the topical experts and,

as a result, their experiences guided and affirmed the findings that emerged through member-fact checking and clarification. In this project, the participants were once again (and arguably always) the experts when it came to their experiences as youth challenged by mental illness, and I was the expert in regard to the dissemination of knowledge to create their opportunities for personal growth and development. This project brought about a particular challenge as youth can be difficult for adults to engage, which made their ownership over the program of particular importance in order for this research to yield the richest data. Equally, my facilitation skills and relatability supported effective interactions with youth, as will be discussed further in chapter six.

It is my belief that rapport building is an essential element when conducting research on sensitive topics. As a researcher, I rely heavily on my ability to communicate empathy, compassion and interest when interacting with my co-researchers. In fact, when engaging in the interview process I often employ approaches recommended to support the therapeutic alliance in therapy. In the context of mental health, the work of Okun and Kantrowitz (2008) reminds us that "an authentic, warm, empathetic relationship between the helper and the helpee is a necessary framework for any kind of psychological change" (p.4). Although my co-researchers are not clients in therapy, within the context of my dissertation, I was both a researcher and a practitioner and I had to own both these roles equally. As such, when employing focus groups and/or interviews, it was important that I maintained a similar communicative approach as I would when delivering my therapeutic recreation interventions. Cripps and Hood (2016) iterate the extent to which a person communicates an accurate understanding of another's perspective remains fluid within any relationship but is underpinned by an ongoing process of communication.

As an interpretivist who is also a certified therapeutic recreation specialist, I comfortably situate myself as a researcher immersed in an action-based project. As such, I play a unique role within my work in that I have the privilege of experiencing an ongoing relationship with my co-researchers that has the potential to facilitate change in their lives, while they possess the power and influence to someday change someone else's. One of the exceptional factors that drew me to the design of this project was the opportunity to engage in a reciprocal relationship with my co-researchers while reminding them of the value they may one day bring to the lives of other individuals who participate in future interventions informed by the results of my dissertation and work thereafter. What I have come to discover about myself is that action-based work energizes me and this energy serves to support me in the face of unpredictable (and somewhat inevitable) challenges associated with conducting social research.

Methods

Central Research Question

How might a therapeutic recreation intervention designed to [broadly] support the development of a positive personal narrative impact adolescents' perceptions of living well with mental illness?

Phase One

Through the unraveled elements of an experience and the relationship that exists between the elements, the researcher can begin to understand the nature of an experience for a particular group of individuals (Moustakas, 1994). The purpose of phase one was to explore the needs of the population through the client-voice. As such, this phase focused on soliciting the lived experiences of the participants through the employment of a focus group. The data were analyzed thematically, and the results informed the preliminary design of the Be Your Best Self-Youth (BYBS-Y) program. Figure 3.2 provides a visual reference for locating phase one within the EIP process.

Phase 1 sub-questions.

1. How do youth describe the experience of living with mental illness?
2. How do youth describe their needs related to mental health services designed to support living well?
3. What is the role of leisure in the lives of youth living with mental illness?

Agency consultation. Prior to the proposal of this project, an informal partnership was established with the Chief Executive Officer of a local mental health organization with agreement that the BYBS-Y program would run within the intensive services sector of the agency. Briefly, the intensive stream provides children and families with support through

counselling and parental training in the home, school and community settings for families who have children who are demonstrating serious emotional and behavioural challenges. The focus of intensive services is to prevent family breakdown through interventions with specially trained family counsellors when traditional counselling is deemed to be insufficient. Following this agreement, the principal student investigator was connected with the manager of residential treatment services for further consultation.

Residential treatment services provide a home-like atmosphere for youth between the ages of twelve and seventeen who have been identified as being unable to function within their own home for a time. Intensive counselling and treatment are provided to the youth along with support for parents and family. The goal is to strengthen the family and provide coping strategies that will enable the youth to return home.

The pragmatics of this project were determined in consultation with the manager of residential treatment services. Prior to proposal, the principal student investigator and the manager met several times to explore how they might best serve one another and collectively determined the details of the program implementation with regard to scheduling. Through this process the start date of the program was added to the treatment schedule, to begin immediately following the 2019 March break, and the days of the week it would run were selected based on flexibility in the agency treatment schedule. The intensive nature of the program was determined based on Manager feedback with regards to keeping the youth connected to the content, and also informed by the previous facilitation experience of the principal student investigator, who had previous involvement with the facilitation of the original Be Your Best Self (adult) program. The plan established between the principal student investigator and the manager of residential treatment services was embedded in the proposal defense at the University and, upon proposal

approval, the first ethics clearance certificate was obtained from the Brock University Research Ethics Board and the second from the local organization before phase one began.

Participant selection/recruitment. Upon receipt of the phase one clearance certificates, the Manager of the residential treatment facility distributed the letters of invitation to the participants and their families, advising them of an information night that was subsequently hosted at the residential treatment facility a week later. During the information night the principal student investigator had the opportunity to speak with families and youth separately to discuss the project and answer any questions they had regarding participation. Clients receiving treatment at the residential treatment facility have an average length of stay between twelve and twenty-six weeks. As such, the participants in phase one were not required to remain in treatment and attend phase three. The three phases were considered stand alone and had separate participant recruitment. Both parental consent and participant assent were obtained in writing prior to the start of the phase one focus group. The criteria for phase one participation were as follows:

1. Must be registered with residential treatment services [organization]
2. Must be have received a formal or informal diagnosis of mental illness from a medical professional either prior to or during their stay at [organization].
3. Must be willing to share their experience of mental illness in either a one on one or group interview setting.

Data collection. The purpose of phase one was to explore the lived experiences and to uncover the expressed needs (and/or preferences) of adolescents who are experiencing significant challenges with mental illness and living in a local group home. This phase represents "consumer voice" as recommended by Drake, Merrens and Lynde (2005) and informed the design changes made to the BYBS-Y program. This phase employed a semi-structured focus group with five participants. In congruence with a grounded approach to interviews, the principal

student investigator entered the experience with a series of broad questions to explore (Table 1), while allowing the opportunity for authentic conversation with the participants (Moustakas, 1994). The interview began with a brief introduction about the principal student investigator and a reiteration of the voluntary nature of the group. The questions listed below in Table 1 were explored informally within the focus group, while allowing the participants to express other considerations throughout. The findings from this experience are discussed further in chapter four. The focus group was conducted in a face-to-face setting and audio recorded on an iPad using the atlas.ti.8 app recording feature.

Table 3.2 – Focus group/Informal Interview Guide

Questions
Tell me a bit about yourself and the kids that live at [treatment home]?
How would you describe your life before arriving here?
What was it like to be diagnosed with a mental illness?
What has it been like to live with a mental illness? Are there certain aspects that stand out to you? What is the impact of having a mental illness on daily living?
When you think of living well with mental illness, what comes to mind?
What do you think has been missing in the services you've received, that you think might be helpful for your recovery?
How does mental illness impact your free time? How is your free time changed by having a mental illness?

Data analysis tools. The audio-coding feature of Atlas.ti.8 was used for analysis, with verbatim transcription of specific quotes throughout. The audio-coding feature allows the researcher to make internal notes on the audio files directly and connect portions of the files to the codes created in the project, the linking codes to central themes. This process of analysis still involved the use of verbatim transcription however, it permitted the researcher to code only the

data they intend to use as direct quotes. The focus groups conducted in phase one were coded for themes and subthemes that were then translated into a visual model and used to inform BYBS-Y program changes and facilitation style.

In Cripps-Torok (2014) I noted the experimentation with and subsequent employment of an older version of Atlas.ti. after comparing analysis of a written transcript to that of a coded audio file. My preference aligned with my auditory learning style and, five years later, still supports my ability to accurately recite large portions of the data from memory. However, most notable to me when I set out to experiment with Atlas.ti.7 five years ago, was the loss of participant voices that happened as I read verbatim transcripts. Indeed, a well transcribed interview will include a change in intonation, laughter, long pauses and other nuances of the interview. The process of analysis through audio-coding is similar to that of verbatim transcripts, however it involves listening to the audio files many times over. For me, this process of analysis was an ideal choice, as it allowed me once again to connect to the words and intonations in the participants' voices, a process that is often lost when using verbatim transcripts. As such, atlas.ti.8 was central to my data analysis process for all audio-recorded data throughout this project.

> Qualitative research design is flexible by necessity, in that the research question may well shift throughout the process of doing the research, and the 'stages' of planning, fieldwork, analysis and writing up are rarely sequential. Each feeds into the others, as the concepts identified at the beginning are refined through analyzing the data and further through writing up the analysis (Green & Thorogood, 2014, p.55).

In this regard, the data analysis for this project was both summative and formative, as the results from phases one and two informed phase three, while phase three informed findings that were then connected back to one and two. This project was intended to be scaffolded and the employment of Atlas.ti.8, supported the ability to maintain visual fieldnotes, written descriptions of experiences, record audio files and maintain ongoing thematic categories and sub-categories for all three phases in order to best illustrate the evidence-informed process.

Data analysis process. A phenomenological approach to data analysis was used in phase one. In accordance with Creswell (2007), the focus groups were reviewed and coded for themes and subthemes that connect back to the central and sub research questions. In congruence with humanistic psychology research, a heuristic process was adopted for the phase one focus group (Schneider, Bugental & Pierson, 2001). Heuristics is a form of phenomenology that is regarded as particularly useful when exploring vulnerable populations and sensitive topics. The purpose of heuristic research is to give voice to marginalized people. By utilizing this method of analysis the lived experiences of the participants remained a central focus of this phase, while valuing the researcher's subjectivity (expertise) in translating this voice into program development (Moustakas, 1990b; Schneider et al., 2001). The phenomenological approach adopted from the six-step heuristic process was as follows: initial engagement, immersion, incubation, illumination, explication, and creative synthesis.

Initial engagement is rooted in the researcher's personal interest in a particular phenomenon and is the catalyst to the research project. In this case the initial engagement was rooted in the purpose of the research and subsequent questions formulated for this pursuit – for phase one it was an interest in the lived experiences of youth with particular recognition that the population is best understood from those within it, as the experience of youth is everchanging

with each generation. According to Moustakas (2001) initial engagement is "The awakening of such a question comes through an inward clearing and an intentional readiness and determination to discover a fundamental truth regarding the meaning and essence of one's own experience and that of others" (p.265).

The immersion stage begins when the researcher becomes fully absorbed in the process of the research, allowing every interaction to lead to deeper understanding of the theme. "The immersion process enables the researcher to come to be on intimate terms with the questions - to live it and grow in knowledge and understanding of it" (Moustakas, 1990b, p.28). In many ways, immersion began with authorship of my literature review and subsequent design of the project. It continued with a proposal defense where I had the opportunity to clarify my values within this project and further refine the design. As the focus group appointment neared, I journaled about pre-conceived notions I had about the population, and how my master's thesis (Cripps-Torok, 2014) interviews still echoed in my head and influenced my expectations. As I conducted the focus group, the vulnerability and openness of the youth inspired me. They entered the focus group with a sense of trust in me, and with that we were able to quickly connect and explore difficult experiences with a sense of openness and mutual respect for one another.

Youth voice occupied much of the discussion with my voice only present when guiding the process. There was a conversational feel to the track that allowed for natural flow between the participants and this further enhanced my connection to the theme and the participants as they spoke about their lived experiences. In many ways, the focus group became a turning point for me within this project, as it was the first time in four years that the research came to life and allowed the opportunity for shared connection with others. Upon completion of the focus group, the audio-recording was reviewed several times prior to making notes, allowing opportunity for

further connection to the experiences shared by the participants. Following each review, I entered a purposeful space of reflection where I would begin to make notations on various themes and subthemes and how they might relate back to the research questions and/or connect to the BYBS adult program. Once my analysis reached a point of reflexive saturation and I felt connections to the research question had been teased out, I then transitioned into the second phase of data analysis – incubation (Moustakas, 1990a; 1990b).

The incubation phase focuses on taking time away from the analysis. The phase highlights the tacit dimension of the heuristic process where the researcher no longer intensely focuses on the theme and thereby allows space for knowledge and intuition to deepen their connection to the research. In this regard intuition bridges the gap between implicit and observable knowledge (Moustakas, 1990b). The incubation phase was particularly important for this project as it allowed space for me to revisit the BYBS program in its original form and begin to formalize a plan for changes based on my clinical knowledge and experience. I did this by printing out the content/process pages and the handouts and taping them to the walls of my office. By visualizing the flow of each session in connection to the next, I was able to bring the program to life in my head and make informed clinical decisions for preliminary design. In the incubation phase I was able to identify a disconnect between the youth I had been with and the handouts and knew I would need to make some visual changes to them for the program. In this phase I also mapped out a preliminary design for the program, eliminating three of the sessions and combining one.

The illumination phase naturally overlapped with the incubation phase as I worked my way through the program development process. Accordingly, “Illumination opens the door to a new awareness, a modification of an old understanding, a synthesis of fragmented knowledge, or

an altogether new discovery of something that has been present for some time yet beyond immediate awareness" (Moustakas, 1990b, p.30). The "ah-ha" moment in this phase was the participant's expressed need to know their facilitator. This resulted in the introduction of an animal theme to the program handouts and which later proved effective as it prompted casual conversations with the participants throughout the program. The youth had voiced that effective therapists were human, and that notion aligned seamlessly with my core values personally and professionally.

The explication phase focuses on the essence of the experience which leads to new knowledge. This phase is about "awareness, feelings, thoughts, beliefs, and judgments as a prelude to the understanding that is derived from conversations and dialogues with others" (Moustakas, 1990b, p.31). In particular, this phase uses focusing as a purposeful tool that "points to a significant idea relevant to personal growth, insight, and change" (p.25). In this phase, the interviews were revisited first with the identification of central themes and subthemes which then subsequently informed the final phase – creative synthesis.

Creative synthesis is the final phase of the heuristic process and involves the synthesis of tacit knowledge, intuition and data. Moustakas (1990b) outlines that in the creative synthesis phase the researcher must "move beyond any confined or constricted attention to the data itself and permit an inward life on the question to grow, in such a way that a comprehensive expression of the essences of the phenomenon investigated is realized" (p.32). This phase led the development of a visual model that represented the findings of the phase one focus group and highlighted the two dimensions that inform effective program design and implementation – content and process. In chapter four the visual model that represents the findings from this phase is presented with a detailed discussion of the components.

Trustworthiness. The validity of a qualitative project can be evaluated through both the process and product of the work (Creswell, 2013). In this regard, a quality project will demonstrate the study of a phenomenon that is better understood as a result of the exploration. This project was not intended to yield generalizability, per se, but instead an explanation of the phenomenon that is youth mental health as described through the participant experiences (Creswell, 2013). Moreover, the data supported coded themes that could be translated back to the research questions and inspired further research considerations. While the use of field notes was essential throughout the process, so too was the ownership of positionality knowing the intersection between subject matter and the lived experience of the principal student investigator (Creswell, 2013).

As a result, I engaged in a process that represents all of the elements of a quality project, as recommended by Creswell (2013). In congruence with Creswell (2013), reflexive practices were maintained through journaling and fieldnotes in an effort to sustain a connection to my positionality as it evolved from phase to phase. Within the journals I actively owned my own experiences with mental health in relation to others, my journey often intersected and informed my communication with others and triggered thoughts about previous personal and research experiences that have led me to this point in my academic career. Transparency was a valuable part of this process, and the fieldnotes maintained are considered to be part of the data. This project is the exploration of the evidence informed process and the potential value of a TR intervention that supports some of the elements necessary for adolescents to live well with mental illness. In this regard, the notion of reliability within the study is thereby irrelevant to this discussion (Creswell, 2013; Denzin & Lincoln, 2011; Guthrie, 2011; Moustakas, 1990).

Phase Two

The purpose of phase two was to solicit feedback on the BYBS-Y program design from Therapeutic Recreation Specialists (TRS) who have been previously identified for their experience working in adolescent mental health services. During this phase a brief outline of each session was provided to the participants who then assigned each session a score and gave optional qualitative written feedback.

Phase 2 sub-questions.

1. What are the key components that should be integrated into therapeutic recreation interventions when developing services for the adolescent living with mental illness?

Participant selection/recruitment. The feedback in this phase was intended to contribute to the validity of the program and to support elements of triangulation of the phase one data. As an educator at Brock University and a Certified Therapeutic Recreation Specialist (CTRS), I have a well-established professional network, however the feedback sought was from practitioners outside of this network. Following the receipt of ethics clearance from the Brock University Research Ethics Board a blanket invitation was sent out to known TR practitioners at five agencies within Ontario. This initial recruitment was unsuccessful as there were no practitioners who met the criteria for participation. A second invitation was then sent out through a closed TR Facebook group for therapeutic recreation practitioners. Upon request, each respondent was sent a personalized email and, as per the REB clearance, consent was assumed upon return on the feedback forms. Twelve responses to the invitation were received and five completed evaluations were returned. The criteria for practitioner participation was as follows:

1. Participants must have at least 6 months experience working with Adolescents in a mental health setting
2. Participants must have completed formal education in therapeutic recreation.
3. CTRS, LRT or Provincial requirements were not a requirement for participation.

Data collection. Phase two represented a broader range of clinical expertise beyond that of the principal student investigator (and supervisors) as a means of better supporting the validity of the BYBS-Y program design. The data from phase two was intended to inform final revisions made to the program design prior to the pilot implementation and evaluation in phase three.

Data analysis. The quantitative data analysis for this phase was completed through the use of Microsoft office Excel. The scores for each session were entered and descriptive statistics were then calculated for the individual sessions and the overall program. The open-ended responses were limited but are discussed in the results chapter. Phase two did not inform any further changes to the BYBS-Y program prior to the pilot implementation. As such, following the completion of phase two data collection, application for ethics clearance for phase three was submitted to the Brock University and Pathstone Mental Health Ethics Boards.

Trustworthiness. Trustworthiness in phase two was maintained through member checking, as summary of the results was distributed to each of the participants with request for further feedback. No further concerns were noted in any of the correspondence, with positive responses iterated by all the phase two participants.

Phase Three

The final phase of this project piloted the BYBS-Y program using multi-method data collection to explore the effectiveness of the intervention and the facilitation. The pilot evaluation took place at the residential treatment facility, with the sessions implemented twice weekly for approximately 90 minutes each over the duration of approximately 5 weeks. Following the implementation of the TR program, participant profiles were generated using the pre-and-post program assessment scores, and the qualitative activity responses from the participant workbooks. Finally, a focus group was conducted with four of the program

participants to further explore the outcome(s) of the program in an effort to understand the lived experiences of the participants within the BYBS-Y program.

Phase 3 sub-questions.

1. What is the impact of a therapeutic recreation intervention on youth with mental illness?
2. What strategies do youth describe as most effective in living well with symptoms, and how might leisure support the development of said strategies?

Participant selection/recruitment. As stated in phase one, this project plan had been reviewed by and received endorsement from the manager of residential treatment at the local organization. The BYBS-Y program was added to the regular treatment schedule for the duration of ten visits. Ethics clearance was received from Brock University and the local organization prior to the start of the program. All residents of the residential treatment home we required to participate in the BYBS-Y program, however participation in the research aspect of the program was voluntary. As per the REB clearance certificates, parental consent was not required for participation, and the option for research participation was left for the youth to decide independently. Consent to participate was not required until the completion of the program, as youth were consenting to the use of their participant profile results within this dissertation and participation in the post-program focus group. All of participants however, expressed interest and completed the informed consent documents prior to the final week. All of the participants in the BYBS-Y program had participated in the phase one focus group, but this was coincidental and not a requirement for either phase.

The criteria for phase three participation were as follows:

1. Must be registered with residential treatment services at [organization]
2. Must have received a formal or informal diagnosis of mental illness from a medical professional either prior to or during their stay at [organization].

3. Must be willing to share their experience of mental illness in either a one on one or group setting.
4. Must be willing to participate in the completion of homework assignments between sessions.

Data collection. This phase utilized both qualitative and quantitative data collection methods. Quantitative methods were represented by using standardized measures for the pre-and-post program assessment scores, and the social validation measures that were completed by each participant following the completion of each session. The pre-and-post assessments were those recommended by the original Be Your Best Self program, as changes to this selection were not reflected in the phase one or two findings. In accordance with best practice, assessment and evaluation are essential elements for programming, as such summative and formative program evaluation were of particular importance to this project (Drake, Merrens & Lynde, 2005).

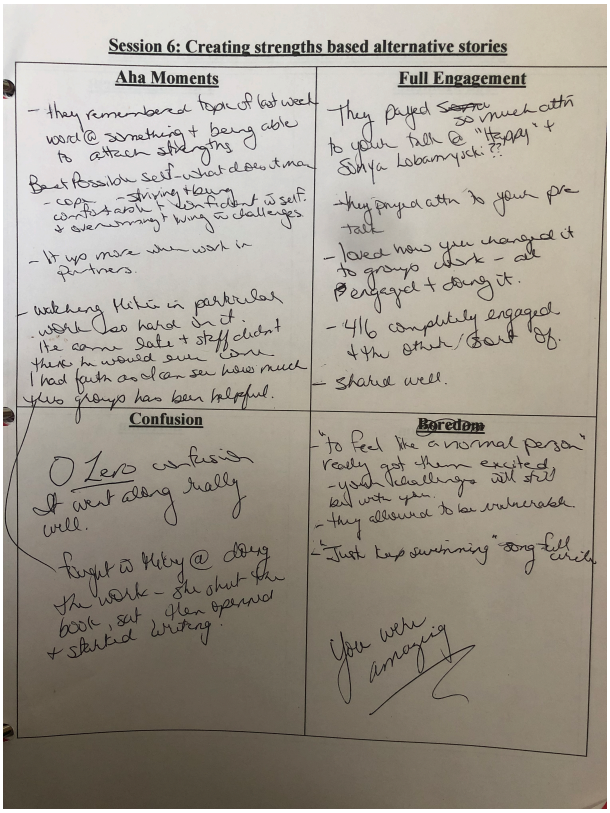
Research Assistant. Upon proposal of this community-engaged research project, there was concern raised about the challenges of boundaries between being a clinician and a researcher. In particular, questions were raised about how the principal student investigator could fulfill both roles effectively in phase three. As such, it was recommended that the services of an independent field note taker be employed during the program implementation so the principal student investigator could focus solely on the facilitation of the program.

The support of a research assistant was sought out purposefully and a CTRS with previous facilitation experience with the original BYBS was hired. The research assistant was required to sign a confidentiality agreement and was payed hourly for their services. The research assistant was introduced to the youth and interacted with them before and after the program but was asked to remain silent throughout the facilitation of the BYBS-Y program and recorded all observations on the session observations form (see figure 3.1). Following the completion of each session, the principal student investigator and the research assistant then

debriefed the experience, discussing their experiences further, which was then reflected in the principal student investigator's fieldnotes. The research assistant did not attend the first or final visit, as observation notes were not required for the completion of the pre-program assessments or the focus group.

This employment of a research assistant, in particular one with previous experience with the BYBS program and a background in therapeutic recreation, added greater depth to the experience as it provided multiple perspectives surrounding the experience from a facilitator's perspective, and also allowed the opportunity for the principal student investigator to unpack challenges with content and/or process to avoid burn out, as the program implementation phase was an intense process from a facilitation standpoint.

Figure 3.1 – Observation Feedback Form



Session 6: Creating strengths based alternative stories

Aha Moments

- they remembered topic of last week word @ something + being able to attach strengths
- Best Possible self - what does it mean - cope - striving + being confident with self + overcoming + living challenges
- It was more when work in partners.
- walking Mike in particular - work too hard on it. the same date + staff didn't think he would even come I had faith as I can see how much this group has been helpful.

Full Engagement

They played so much attn to your talk @ "Happy" + Sonya Lobamyski??

- they payed attn to your pre talk
- loved how you changed it to groups work - all engaged + doing it.
- 4/6 completely engaged + the other/ part of.
- shared well.

Confusion

0 Zero confusion
It went along really well.

Bright @ Riley @ doing the work - she shut the book, sat then opened + started writing.

Boredom

- "to feel like a normal person" really got them excited
- your challenges still stuck with you
- they allowed to be vulnerable
- "Just keep swimming" song fell with

You were amazing

The pre- and post-program assessment tools for the BYBS-Y program were consistent with those utilized in the BYBS adult program, as the outcome measures of each remained relevant to the program evaluation.

The assessment tools used for pre- and post-program measures were:

1. The Stages of Recovery Inventory (STORI-30) (Andresen, Caputi, & Oades, 2006); The STORI-30 is a 30-item measure that targets psychological recovery and personal growth and assesses where clients are in the process of recovery (identified as stage of recovery) from mental illness. Items on the scale represent the four elements of recovery identified by Andresen, Oades and Caputi (2011) – hope, identity, meaning, and responsibility.

2. The COMPAS-W Scale of Well-Being (Gatt, Burton, Schofield, Bryant, & Williams, 2014); The COMPAS-W is a 26-item scale that measures 6 subcomponents related to wellbeing: Composure, Own-Worth; Mastery; Positivity; Achievement; and Satisfaction. The scale can be used to identify participants as Languishing, Moderate, or Flourishing.

3. The selected subscales of the Wellness Evaluation of Lifestyle (Myers, Sweeney, & Witmer, 2004); Myers et al. have identified eighteen characteristics that are associated with optimal health and well-being. Six subscales have been selected as being relevant to the purposes of the BYBS-Y program: Sense of Worth (5 items); Sense of Control (5 items); Realistic Beliefs (6 items); Emotional Responsiveness (6 items); Stress Management (8 items); and Leisure (6 items).

4. The Adolescent Mental Health Continuum – Short Form (MHC-SF) (Keyes, 2008); The MHC-SF is a 14-item scale that measures emotional well-being, psychological well-being, and social wellbeing.

5. The Strengths Knowledge Scale (SKS) (Govindji & Linley, 2007); 8- item scale that measures knowledge of personal strengths.

6. The Silver Linings Questionnaire (Soderngren & Hyland, 1997); 38-item scale that measures optimism and post-traumatic growth.

Social validation measures are questionnaires that are used to determine participant satisfaction following an intervention (Foster & Mash, 1999). At the end of each session, participants completed 5 questions in which they indicated a value from 1 to 5 on their perceptions of the importance of the topic; their sense of improvement in the skills related to the topic; and their confidence that they would be able to use the skills and concepts in their lives

outside of the program. Social validation scales were collected from participants at the end of sessions one through seven and were part of the program evaluation data.

Descriptive Statistics. Quantitative data that were collected in phase three were limited to descriptive statistics and the data were only intended to illustrate the categorical changes in order to generate a participant profile for further discussion. These data were collected through written pre- and post-program assessments. A social validation measure using a Likert scale was collected after each session to illustrate the utility and effectiveness of each session. The quantitative data were analysed using the data analysis feature in Microsoft Office Excel and reported through the use of a graph in the participant profiles. The results of the pre-and-post program assessments and social validation were used to create a mean score that quantified the effectiveness of each session and the overall success of the program.

Given that this was a pilot evaluation, the purpose was to take a preliminary look at whether the instruments were appropriate for the evaluation of the program and explore how the program was received by youth. While sample size in this pilot evaluation was not large enough to perform parametric statistics, non-parametric statistics were simply beyond the scope of this project (Neuman & Robson, 2009). The purpose of the descriptive statistics used throughout this dissertation is to illustrate preliminary evidence regarding the effect. This project provided opportunity to pilot the evidence-informed process with BYBS-Y while also generating some preliminary data that speaks to the decision-makers in the health care arena, knowing that qualitative data alone would be undervalued in this regard.

Qualitative Analysis. Qualitative data were collected in the phase three post-program focus group and were analyzed and coded thematically, connecting back to the primary research question and sub questions, as well as the previous findings in phases one and two. Atlas.ti.8.

was employed for this process as described previously in the chapter under the data analysis tools heading for phase one.

Phase three post-program focus group data analysis followed a revised heuristic process as used in phase one. The immersion in this phase of the research began with the implementation of the program. Although the role of the principal student investigator was to facilitate while the research assistant observed, it seemed unrealistic to suggest that one can disconnect from the research process completely in this way. As such, fieldnotes and journaling were practiced following each session and included clinical insights and collaboration with the research assistant. Following the completion of the post-program focus group, the audio-recorded interview was listened to several times, with additional notes made in connection to the phase one visual image and field/observation notes.

The incubation phase began once the interview had been reviewed half a dozen times and connections to themes had reached a point of saturation. The incubation phase created space for reflection on the experience and allowed space for the tacit dimension of the process to be honoured. The illumination phase began naturally through various conversations about the implantation and subsequent feedback. In this phase the ‘ah-ha’ moment was the enlightenment that effective program delivery is equally dependent on content and process – a notion that I had underappreciated in previous clinical spaces. The analysis of the phase three post-program focus group ended in the explication stage which highlighted the anticipated and unanticipated findings in connection to themes and subthemes and were subsequently reported. The findings from the qualitative and quantitative data analyzed in phase three are discussed in chapter six.

Trustworthiness. Trustworthiness in phase three was maintained through member checking. The quantitative results were explored during the post-program focus group with

participants. An individual participant profile was provided to each of the participants and these findings were further explored for meaning. This purpose was two-fold: it confirmed that the interpretation of quantitative findings, indeed represented the participant experiences; as well, it provided the opportunity to explore discrepancies and to deepen the understanding of the participant experiences in the program to better evaluate the effectiveness of the program and subsequently to inform future program changes.

Positionality

As I think about my positionality within my proposed research, I find myself asking *why this study*? What I now realize is that there are many reasons. This work connects to my sense of agency, it facilitates my thirst to inspire change and it enriches the personal and professional connections I have in mental health services. It is my belief that the number of breaths one takes cannot define a life, but rather we find our deepest meaning in the moments that take our breath away. In 2004, at 21 years of age, I was diagnosed with Major Depressive Disorder. Consumed by suicidal ideation, I was lost within myself and unsure if I would ever accept this new identity. As an individual learning to live with depression, my life quickly became a journey that looked nothing like one would have guessed it to be in my early teen years. What I discovered through my master's research, is that learning to live with a mental illness becomes a central theme in everyday life, it requires commitment and discipline, it is consumptive of physical and emotional energy and it disrupts a person's schema in a way that often feels unbearably isolating. And yet, in recovery, my story now supports expressions of gratitude, and a commitment to the potential of helping others achieve much the same (Cripps-Torok, 2014).

Creswell (2013) suggests that it is nearly impossible for researchers to fully disconnect from their own lived experiences. Therefore, in order to conduct quality research, they must

employ methodologies that allow them to position their experiences in a way that supports reflexivity but does not overshadow the data. As I consider my journey of recovery in relation to my research, I can't help but acknowledge my own inability to separate myself from my experiences, therefore I will instead choose to honour it as my guiding force. However, it is my belief that my experiences of learning to live well with a mental illness provide a positive contribution to my research, particularly by facilitating insider status (Creswell, 2003; 2013; Jones et al. 2014). In previous work, my experience with mental illness supported building trust and rapport with those involved such as gatekeepers and co-researchers. Within my current doctoral work, my experience as a mental health practitioner who has lived experience with mental illness, lends credibility to my program development and subsequent facilitation skills. Residing in the interpretivist paradigm supports the space necessary to acknowledge my own experiences while searching for deeper understanding and uncovering aspects I have not yet considered (Jones et al., 2014). It is through my interpretivist lens that I am able to explore the experiences of others in relation to and separate from my own, in an effort to illuminate the phenomenon of living well with mental illness (Angen, 2000; Black, 2006; Creswell, 2003; 2013; Ferguson, 1993).

Steinberg (2017; 2020) and Shatkin (2014) emphasized that the unique culture of adolescence can only be understood from within that particular cohort. As such I am an outsider from my co-researchers in this regard, given that my adolescent experience took place in a different generation and therefore likely represented a culture that is different from our current one. Nonetheless, I situate myself at the forefront of a program of research that seeks to explore the role of therapeutic recreation interventions for adolescents living in a group home for individuals challenged by mental illness. Within this project I sought to understand and support

the skills and capacities deemed necessary for adolescents with mental illness to live well. Through the theoretical integration of a broad range of psycho-social literature, the interventions provided participants with the opportunity to explore a deeper understanding of themselves, their experiences and their potential to live well.

When I think critically about my positionality within this project, I always come back to the same question: *what is it about my experiences that have led me to want to study mental health?* When I began graduate school, it was important to me that I embody a program of research that honoured my core values (honesty, integrity, authenticity, excellence, courage and gratitude) while providing opportunities for personal and professional growth and supporting social change. As an individual living well with mental illness, my story of recovery and my experience of living well have remained central to my motivation as a researcher. However, as a result of my intimate experience with the phenomenon I study, reflexivity is essential to my process and impacts the trustworthiness and authenticity of my work (Angen, 2000; Black, 2006; Creswell, 2003; 2013; Ferguson, 1993; Moustakas, 1994).

In previous research I have implemented strategies to assist in bracketing my own experiences. I maintain fieldnotes throughout the experience and write reflective journals regularly. This helps me stay connected to my own reality and revisit how it was shaped by my engagement within my research. Within my journal I recorded the thoughts and emotions of this process as I experienced them, as well as the coping strategies I employed in moments of challenge and excitement (Creswell, 2003; 2013; 2013; Denzin, 2011; Moustakas, 1990; 1994). In this project, I continued to use fieldnotes and journal in every phase and these entries also became part of the data.

When I think critically about my positionality I can’t help but further acknowledge the

intersection that exists between my personal story and my professional status as a recreation therapist as well as my life as an aspiring academic, although within the positivist or post-positivist paradigm, I might consider this to be a limitation. Positioning myself in the interpretivist paradigm allows me space to explore my experiences as complimentary to the work I do, while acknowledging that my own experiences impact how I construct reality.

My research is rooted in my desire to motivate and inspire individuals with mental illness in knowing that living well is possible. In addition, it is my hope that through my programs I am able to improve the quality of services available for individuals with mental illness and influence the current structure of the mental health care system. However, what I have quickly discovered is that sharing my story within my research platform has left me with a deep sense of vulnerability and an overarching fear of judgment in the academic world. There is nothing safe about sharing your story with others, especially when it involves a subject that is so heavily stigmatized. A component of living well with a mental illness is being authentic, so I choose to take pride in my work knowing I have engaged in research that is congruent with my whole self and will continue to do so throughout my career, despite the intense vulnerability I feel in doing so. It is my hope that by allowing myself to be vulnerable, my work will give new meaning to others and create space for others to begin the conversation about their experience with mental illness and the subsequent life they live that includes this challenge but isn't defined by it.

I acknowledge that I operate from a very westernized and privileged lens, which influences the value I place on leisure engagements. Although I do believe leisure can be transformative, I also acknowledge that my experiences with leisure are very much conspicuous (Brightbill, 1960). As I reflect critically on my ability to live well with a mental illness, I recognize that much of my potential stems from my socioeconomic status. As a result, I believe

it is necessary to acknowledge that recovery from mental illness may not be universally accessible. In fact, we know that individuals of higher financial means are more likely to recover from and live well with mental illness (Aneshensel & Sucoff, 1996; Jenkins, Baingana, Ahmad, McDaid, & Atun, 2011; Wadsworth & Achenbach, 2005).

Aside from the influence of socioeconomic factors, there are additional assumptions with regards to leisure that have resulted from my westernized view and are embedded within my program of research. First, as a certified recreation therapist I ascribe meaning and value to my own leisure experience, which likely is a preconception that influences how I interpret data. Second, I emphasize that leisure, though entertaining, is about purposeful engagement in (free time) activities with the intent of a preferred experience. As a leisure scholar, I have a unique view of leisure that is heavily influenced by the world in which I study. However, within the context of my therapeutic recreation programs, I am purposeful in excluding the use of terminology unique to our field (such as leisure) and replace it with accessible language which is helpful for generating more authentic discussions within sessions.

Lastly, I do believe that leisure provides an opportunity for transcending negative life events through the facilitation of positive emotion and increased resiliency. As a result, I believe (and promote) leisure as a space for freedom, self-expression and self-directed development that assists in one's recovery from mental illness (Kleiber, 1999). However, this assumption is both a perpetuation of my personal experience with mental illness and my professional background as a therapeutic recreation professional. Moreover, it is within this assumption that I have to actively remind myself that in the face of mental health challenges immediate capacity to engage in leisure does not always exist and therefore requires supportive opportunities for development.

My masters project explored a unique group of individuals who live well with mental

illness and have created a life rich with meaning through their experiences. This work was in no way generalizable to the overarching mental health population, but it certainly has given me some valuable insights into the lives of others. Yet, within this project, I equally must own the influence my previous work has on how I construct my understanding of recovery-based skill development, not to mention the experience I have gained through the process of conducting qualitative research. The experience of completing my masters inspired me to go on to pursue a PhD. Over the past seven years as I've progressed through my graduate student career a lot has changed, I've shifted focus from the adult mental health population to adolescents; I've become a mother (and step-mother) to four children; I've divorced and remarried, and I've begun to tell the one part of my story I had always intended to keep from anyone who met me thereafter. In this process, I've created space for the unexpected, I've connected to deeper meanings and uncovered aspects of myself as a researcher, practitioner (and person) that likely would have otherwise remained hidden. As I work towards conducting and subsequently defending this final piece of my student career, I will continue to be reflexive and to make space for the unexpected knowledge that emerges as well as the possibility that what I hope to create may look nothing like I once envisioned it, but perhaps it will be better!

This multifaceted project is intended to be an action-based theoretical integration of the current body of positive psychology literature that works to evaluate the social psychology of free-time engagement (leisure). This research has the potential to fill a void in the current body of sociobehavior, social psychology, and leisure studies research. However, through the translation of theory into practice, this research is equally relevant to Canadians as it works to combat the well-documented social issues associated with mental illness and has the potential to provide accessible opportunities for effective treatment within this population. In addition, at the

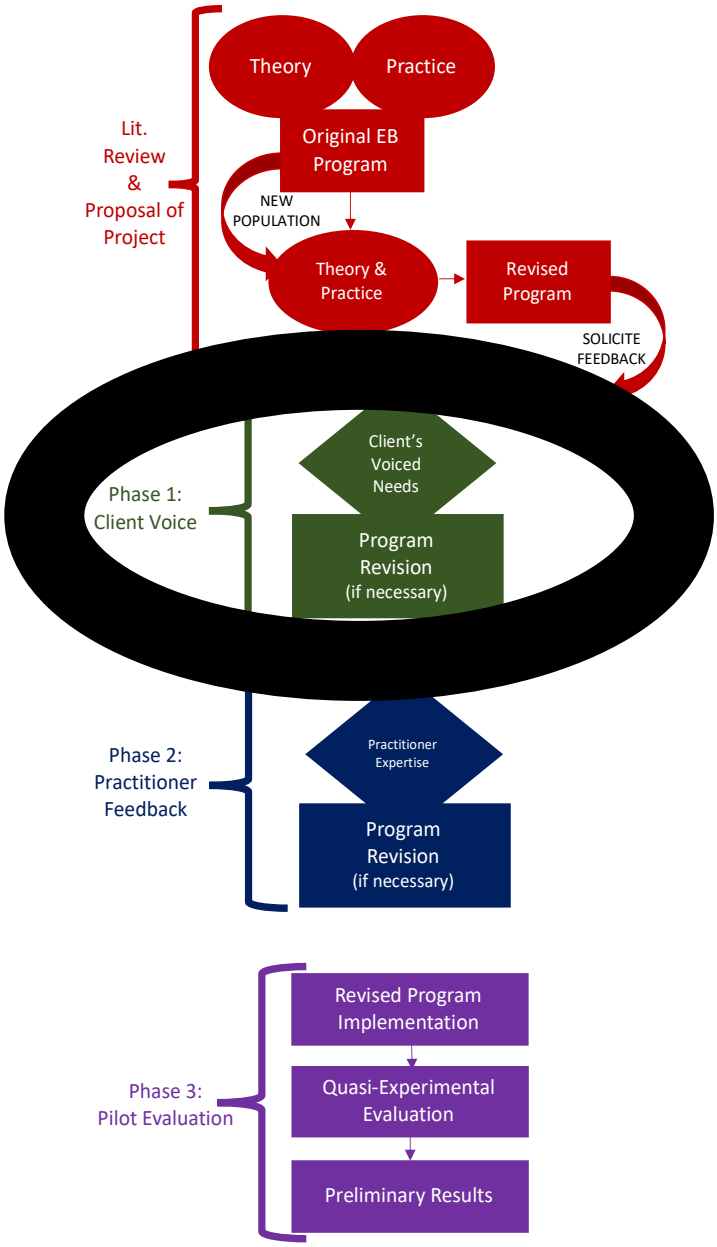
administrative level, this research has the potential to reduce rates of re-hospitalization through the enhancement of therapeutic recreation and recovery-based services at the regional, provincial and national levels. As Davidson and colleagues (2001) found, ongoing purposeful activity in daily living provides participants with a sense of normalcy within a life that is otherwise dominated by treatment appointments. In addition to respite, their research identified that leisure engagements provide individuals with mental illness the opportunities for connectedness and an increased sense of hope and savouring. When reflecting upon this work, Davidson (2006) wrote "This sense that life has something more to offer than just disease, disability and despair appears central to people's ability to remain hopeful in the face of persistent dysfunction and disappointment and to become committed to making things better" (p. 156). This highlights the sense of agency that has inspired my program of research and my doctoral dissertation.

Chapter 4 – Phase One Results: Client Voice

Literature supports that leisure, well used, can be supportive of both adolescent development and recovery from mental illness (Anderson & Heyne, 2012a; Carruthers & Hood 2007; Hood & Carruthers, 2007; 2013; Hutchinson, Bland, & Kleiber, 2008; Hutchinson, Bland, & Kleiber, 2008; Kleiber, Hutchinson, & Williams, 2002; Kleiber, Reel, & Hutchinson, 2008; Kleiber, 1999; Lyubomirsky, 2007; Lyubomirsky & Layous, 2013). The purpose of this project was to explore the value of purposeful integration of therapeutic recreation interventions for youth living in a group home setting. The central research question for this project was: *How might a therapeutic recreation intervention designed to [broadly] support the development of a positive personal narrative impact adolescents' perceptions of living well with mental illness?*

In phase one (REB 18-138 HOOD), client values were explored to ensure that the program aligned with the expressed needs of those it was intended to serve. In phase two (REB 18-230 HOOD), feedback on each session was sought from several TR practitioners employed in adolescent mental health in both Canada and the United states in order to strength the clinical expertise that backed the program. Finally, in phase three (REB 18-249 HOOD), the program was implemented, and pre- and post-program and built-in measures were collected for further evaluation. Figure 4.1 provides a visual reference for locating phase one within the EIP process.

Figure 4.1 – Locating Phase 1 in the Evidence-Informed Process



Phase one: Client values

The purpose of phase one was to explore the needs of the population through the client-voice. This phase focused on soliciting the lived experiences and expressed needs of the participants living at a local residential treatment facility for adolescents aged 13 to 18 with ongoing mental health issues.

The sub-questions specific to Phase One were:

1. How do youth describe the experience of living with mental illness?
2. How do youth describe their needs related to mental health services designed to support living well?
3. What is the role of leisure in the lives of youth living with mental illness?

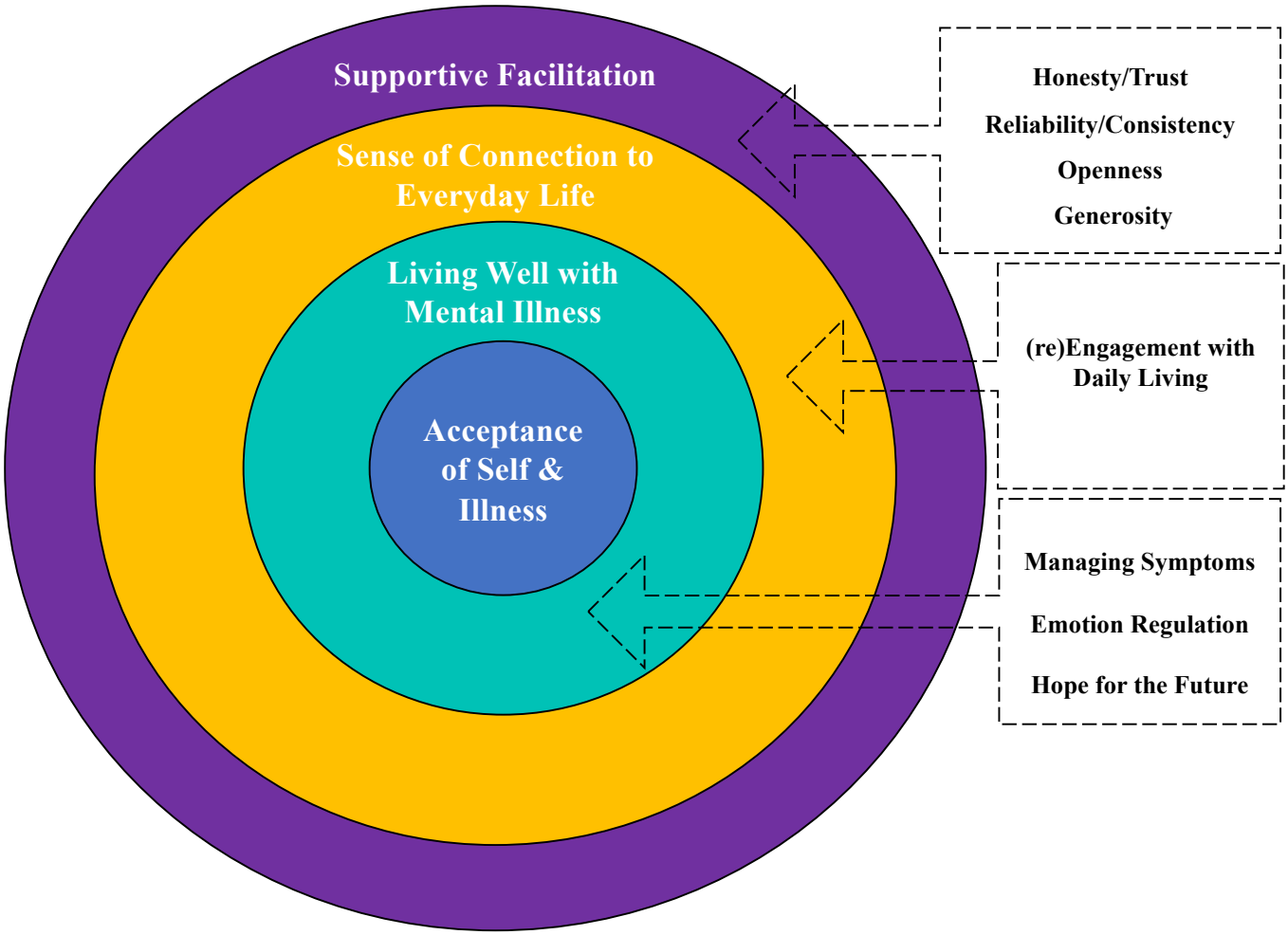
Participants

The focus group for phase one was 80 minutes in length. It was conducted as a stand-alone interview and was not connected to participation in phase three (program implementation). The focus group was conducted in person with youth and took place in the treatment room at the local organization. There was a total of five participants in the focus group, ranging in age from 14 to 17 years of age. Parental consent was collected prior to the focus group, and youth assent was collected in person prior to the start of the focus group. Three of the participants self-identified as female on the informed consent and two participants self-identified as male (transgender, transitioning to).

Findings

The purpose of the initial focus group was to explore the needs of the population through the youth voice in an effort to ensure that the design of the BYBS program was in line with their experiences. The findings from the focus group supported three primary themes (1) living with mental illness, (2) need for connection in everyday life and (3) effective facilitation and support. Figure 4.1 represents a visual translation of the findings which subsequently informed the BYBS program. At the core of the model is the acceptance of self and illness, as this process is foundational to one's ability to explore wellness. Next one begins to explore independent strategies that increased functionality. Third, one begins to re-engage with daily living and the possibility that a more satisfying life is possible. Finally, this process is encapsulated by supportive facilitation, as the findings supported youth needing meaningful professional relationships to be engaged in treatment. The remainder of this chapter will describe the findings from phase one and includes purposeful quotations from each of the focus group participants. In an effort to maintain an authentic flow in conversation within the phase one focus group the participants were asked not to identify themselves prior to speaking and the quotations therefore do not include attachment to a particular speaker.

Figure 4.2 – The Experience of Youth Living with Mental Illness



Acceptance of Self and Illness

The notion of acceptance was present in much of the conversation surrounding mental illness and the participants' lived experiences. One participant was quick to explain that acceptance is foundational to re-establishing wellness.

> *You have to be ready to move forward and accept help for anything to work. Living in this house we see it a lot. Kids coming in for a week or a month and leaving because they aren't ready or they don't see themselves as being as sick as the rest of us, so they don't belong…until you see the whole picture and realize you do need help and there's a lot of work to do that will last a lifetime, it's pretty much impossible to be anything but your illness.*

Shortly thereafter, another participant highlighted that acceptance is highly individualized and somewhat complicated given the vulnerability it mediates.

> *Having to do it yourself is like the hardest thing ever because you have to admit to yourself that you're sick and need help, and no one likes to do that…No one wants to admit to themselves or others that they're actually going through a really hard time, because it's embarrassing. For the longest time, I would never admit to you that I have problems or that I can't do things that I used to because it's embarrassing to me, like for yourself, looking at what you used to be able to do and what you can't do now and what you no longer have interest in is just so embarrassing for me and it just takes so much out of you. Like, I want to get back to that spot but I don't even think I can because I'm so low, like you know, but you have to teach yourself how to build life back up and get better, but it's the littlest things that can break us and putting the pieces back together is such a slow process because we're so vulnerable…I get that people suggest*

you should get help, but honestly that's not really how it works. It's you, yourself having to change. There's no magic pill that will fix everything, it's YOU that can fix it, but that's also really scary.

Living with Mental Illness

Agency/voice. In chapter two it was suggested that employing agency with youth is of particular importance when it comes to meaningful program design as they hold the greatest insights into their own needs and are the best informants of their cohort. Consistent with this, the participants identified a need for voicing their thoughts and opinions**.** They iterated that they hold a degree of expertise for their own experience and the experiences of those around them in similar circumstances, therefore having a voice in their own treatment process and feeling valued for this was important for them.

The only people who are really educated about mental health are the ones who live with it, so if you want to understand more, ask us – like you are right now. A good therapist in my eyes is someone who doesn't treat you like a kid who doesn't know anything about themselves, or who knows better than you do. Because I've had psychiatrists and therapists, people who were there and supposed to help me, but the way they look at it is like, well I'm a kid and I have these issues, but again I'm a kid, so like I couldn't possibly know anything because I don't have the degree, so they are there telling me what's wrong and what I feel, no matter how much I tell them that's not it, they don't listen. So I'm left feeling like no one will ever listen to me, even though I know myself and what I feel far better than anyone will ever know for me.

Managing symptoms. Consistent with the literature review, the participants described living with mental illness as having an impact across all aspects of their life. When asked, they

expressed feelings of isolation, helplessness, low motivation, lethargy and anhedonia – all of which correspond with symptoms of mental illness.

> *I think living with mental illness, like how I describe it is like being in a hole and you have people surrounding the hole and it's like you have all these great people around you, people who love you, who want to support you but like you truly feel alone no matter what your mental illness is, cause like, you feel like you can't really relate to anyone and all you want is help but you're in this hole looking up at people who are all surrounding you, you know….it changes everything! ["100%" echoed in background], you can't like, again it's like being in a hole and everything is just nothing compared to wanting to be happy but feeling hopeless…nothing compared to just wanting to sleep and let me not wake up all day. I don't want to do anything, I don't want to wake up, I don't want to talk to my friend, I don't want to brush my teeth, I don't want to get out of bed. Like, you don't want to do physically anything because it [mental illness] changes your whole life.*

The unmanaged symptoms of illness were described as impacting the participants' ability to function within their everyday life and were also a central focus for how they envisioned living well. For the participants, living well was about developing the capacity to tolerate the recurring challenges associated with illness, rather than eradicating it.

> *I know that my PTSD will never go away, like I'll always have it but I just think I live with it having less of an impact on me, like, a life where, um, a life where I can go on with my day even though I have a flashback, or just have less of it and be happy – not worrying about going out in public and having a flashback. Just being confident that it's okay that I have this and that not everyone needs to understand it, and it's okay if other*

people don't understand it either, but I can just live a life that allows me to do normal things without having to always be focused on what might happen if I try to.

In this regard, the participant perspectives were in line with the recovery literature, with a primary focus on a life that includes but is not defined by illness.

Emotion regulation. Unmanaged emotions were described as impacting both school and work life, resulting in dismissal from classes and being sent home from work. The participants discussed challenges in the context of being unable to tolerate things that 'normal' people their age would be relatively unaffected by. In addition, they described carrying uncomfortable experiences with them for prolonged periods of time, which then impacted their ability to move forward in their day.

I find a lot of the time it depends on the day with my mental illness and it sounds shitty, but like, how you wake up in the morning, like that kind of like dictates how your day is going to go. I've known that for a couple of years, I just never realized it was because I was mentally ill. I knew that if I had a bad morning, I was going to have a bad day, if I had a good morning, I was going to have a good day. I never really put two and two together until after I was diagnosed. I never really realized until after that if I had a conversation with my mom in the morning that upset me, a normal person would be like oh okay and move on, but me, I'd be like in the bathroom crying at lunch because my mom said something that upset me a little and I just can't move on.

The participants described challenges with distress tolerance throughout the focus group. This theme held central connection to relationships with others and autonomous pursuits. As the participants described challenges, it was noted that their parent actively worried about triggers that could happen in social situations which could lead to unmanageable emotions and a lack of

confidence or perhaps faith in their child's ability to tolerate such. The participants gave context to parental concerns as they spoke of their self-harm habits.

> *And like our brains aren't fully developed so once you have feelings of self-harm, it's really hard to tell from right to wrong, all you know is how you feel in the moment and you don't see the future. You definitely don't think you have a whole life to live, it's just if I die then everything will be over and I won't have to feel this way anymore. And then this becomes your sense of self, you're lost in yourself and you don't want to do anything, you don't want to live because you don't see yourself ever being good enough for anyone, or you don't think that relationships will ever work for you.*

All five of the participants disclosed participating in intentional self-harming behaviours prior to admission to residential treatment facility, with four of the five participants indicating cutting was a primary strategy employed for managing negative emotions, *"it's really hard to explain, sometimes the only thing we can do is cut, because it gives us a bit of relief I guess, in the moment it's like you're in control of what happens next"*.

When prompted to share some insights as to what might be helpful in supporting their own recovery, they consistently spoke of their current ability to tolerate distress. "*Being able to cope with it, without having breakdowns all the time. Where like you can be out doing something as simple as grocery shopping and have something trigger me to feel something uncomfortable and then I immediately know how to use coping skills to deal with it and be like – ok I can do this, I can keep going*" [agreement echoed in the background].

> *Also, a lot of people go towards treating people with mental illness as getting rid of the illness rather than treating them to be able to live with the illness and be able to cooperate with their illness to get through life because the thing is, you may be able to go*

through parts of your life without the symptoms anymore but they are still always in the background. You could go five years, ten years, whatever, without struggling but then suddenly they're back, so being able to cope with them and understand the difference between your illness and you would make it easier. Having the chance to learn how to work in partnership with your illness rather than just fighting it all the time would make life a lot easier

The participants consistently voiced constraints on their social lives, suggesting that their inability to demonstrate emotion regulation and tolerate any sort of distress was often transferred into other contexts and had social consequences.

It comes to the point of them being like, overly like um presumptuous. Say you have a sibling and this sibling can kinda do whatever they want, you know, and then you on the other hand, they're like no you can't do like what your sibling's doing because you have this mental illness and this is restricting your ability to do that… because people think of illness in terms of the stereotypical presentation and don't get that we're all different, just because someone over here can't do this because it will trigger them doesn't mean I can't do it and so it's hard

Throughout the focus group the participants articulated a clear desire for 'typical' teenage experiences with regards to leisure and relationships. Such experiences were most often described in the context of parental constraints, with little accountability for behaviours that might have led to such concern. The participants expressed feelings of frustration surrounding opportunities with friends when it involved time away from their own family.

You're like a normal teenager going through normal teenager things with some extra complications on the side that don't help it, but like any normal teenager you want to

hang out with your friends and sure they may have a mental illness or they might have something else, but would your parents stop you from going to see them because they have a broken arm? Would your parents stop you from going to see your friend because they have a concussion or because they just got out of the hospital because of surgery, like no! Oh like they have a broken leg, great, they're probably bored sitting up in their room and could use the company - sure you can go over. But when it comes to mental illness if you don't have parents that are looking at it through eyes of, like kind of, this is something that some people in general have to deal with and instead of alienating them, be like that's fine it's not who they are it's just something they're dealing with and of course you can spend time together. But that's not what most parents are like!

Developing Hope Through Autonomy/Agency

As previously discussed, the participants described an ongoing desire for normalcy, yearning for opportunities to explore relationships outside of their nuclear family unit. Although this desire was primarily discussed in the context of barriers, it also serves to support the concept of autonomy as this desire is rooted in the natural process of disconnection and reconnection that is part of adolescent development. Moreover, the participants spoke of their need for knowing that their future would be somewhat in contrast to their current circumstance. For them, the thought of living independently knowing they could someday manage day to day life without the level of assistance they currently required generated a sense of hopefulness for the future and, in turn, provided a sense of purpose for treatment at the present time.

When asked what living well with mental illness would look like the participants were quick to respond with descriptions of an autonomous life, suggesting that living well for youth is rooted in knowing that an independent adulthood is possible. *"To me, it's about living life WITH*

mental illness AND being happy, I've always looked at that like a dream. And I see people do it, so I know it's possible, I just want to know that I can get there too." In this regard, it was clear that the participants had realistic visions of their future that included illness and were somewhat open to exploring strategies that might support getting there. When asked to describe what it would mean to live well, another participant explained how they envisioned a life that was filled with connections to others.

"Honestly, living a normal life is like my only dream. I want to become a paramedic, have a house and end up with someone I love and maybe even a family of my own. Like that's all I want in the world, I don't want money or fancy things. I just want to know when I grow older, I can have a life that I can live happily." Such discussions made it clear that youth envisioned a life that included others but was autonomous. The idea of having a life that could facilitate a primary relationship further served as reason to get well and stay well. For the participants, knowing they could someday have an opportunity to make their own choices about housing, careers and relationships provided a tangible goal and became a focus for them in big picture conversations. This notion is congruent with the adolescent and recovery-based literature which suggests that adolescent development is complete when one transitions into an autonomous life stage, while recovery involves a sense of agency for one's own health and well-being.

> *For me, the end goal of treatment is to be able to live on my own without having to call crisis services every time I have a breakdown. Without needing to call my parents, without having to have everything locked up because oh I'm a troubled kid. I don't want to be seen as that, what I want is to be seen as the kid that did it, the kid that overcame all the shit that life had to throw at me and now lives a great life.*

> *For me, in my eyes, living well with a mental illness would look like having the ability* [access to resources] *to choose suicide or self-harm, and not doing it. Having the ability to do something that would make everything better, in the sense that you won't have to deal with any of it anymore but not doing it because you know that everything is going to be fine, and being able to actually admit to yourself without it sounding like a lie, that everything is going to be fine.*

Sense of Connection to Everyday Life

(re)Engagement with daily living. The intention of the phase one focus group was to gain insight into the lived experience of youth living with mental illness, with particular interest in how the participants described experiences in their free time (leisure). In the previous section the participants described unmanaged illness as having an impact on their ability to gain access or privilege to social opportunity, but the consequence of illness on free time extended beyond opportunity and was significantly impacted by lethargy and anhedonia/disengagement.

> *The thing with free time is that, like, for a lot of people with mental health issues – say for example anxiety and depression - it's really hard for them to do the simplest things like get up in the morning, go to work, go to school or get to appointments or anything like that. But once you're adding the whole thing of free time activities like extracurriculars or sports or clubs and things, like it's hard enough for us to get up to get to school to be able to actually graduate, but it's like if we could, we would do more than that, sports, extracurriculars, we would do things like that but it's like for the most simplest things we have to exert ourselves to the max. We have so little amount of energy to put towards these things that are supposed to be so normal and easy, that when it comes to the other stuff, the things you want to do, you're just done- there's*

> *nothing left. It's like I would, but I can't, I'm too done, I'm too tired and I just can't deal with it. Or it's like it doesn't seem interesting, that's my biggest issue, even if I have the energy, I don't have any interest in doing it – there's next to nothing that I would do that actually seems interesting to me.*

Mental health challenges were also described as creating a disruption in identity and previous engagement with activities the participants did prior to illness. Although it was obvious that each of the participants had previous experiences in organized activity, none of them described unorganized engagements as a previous or current practice. *"I've lost all interest in the things I used to love doing…I was a gymnast for most of my childhood, after I hurt my knee I was devastated that I couldn't keep competing, after about a year, it was like oh well who cares, and now I have no interest in anything to do with any sport, even though it once gave me so much joy".* As echoed by other participants, *"I completely agree, I used to play soccer and it was my first love, now I won't go back to it because I have no interest in it anymore, I don't even bother watching it on TV because I just don't care"; "Yeah, I used to look forward to the Olympics and idolize the athletes, and now I'm like 'oh, the Olympics suck, who cares' ".*

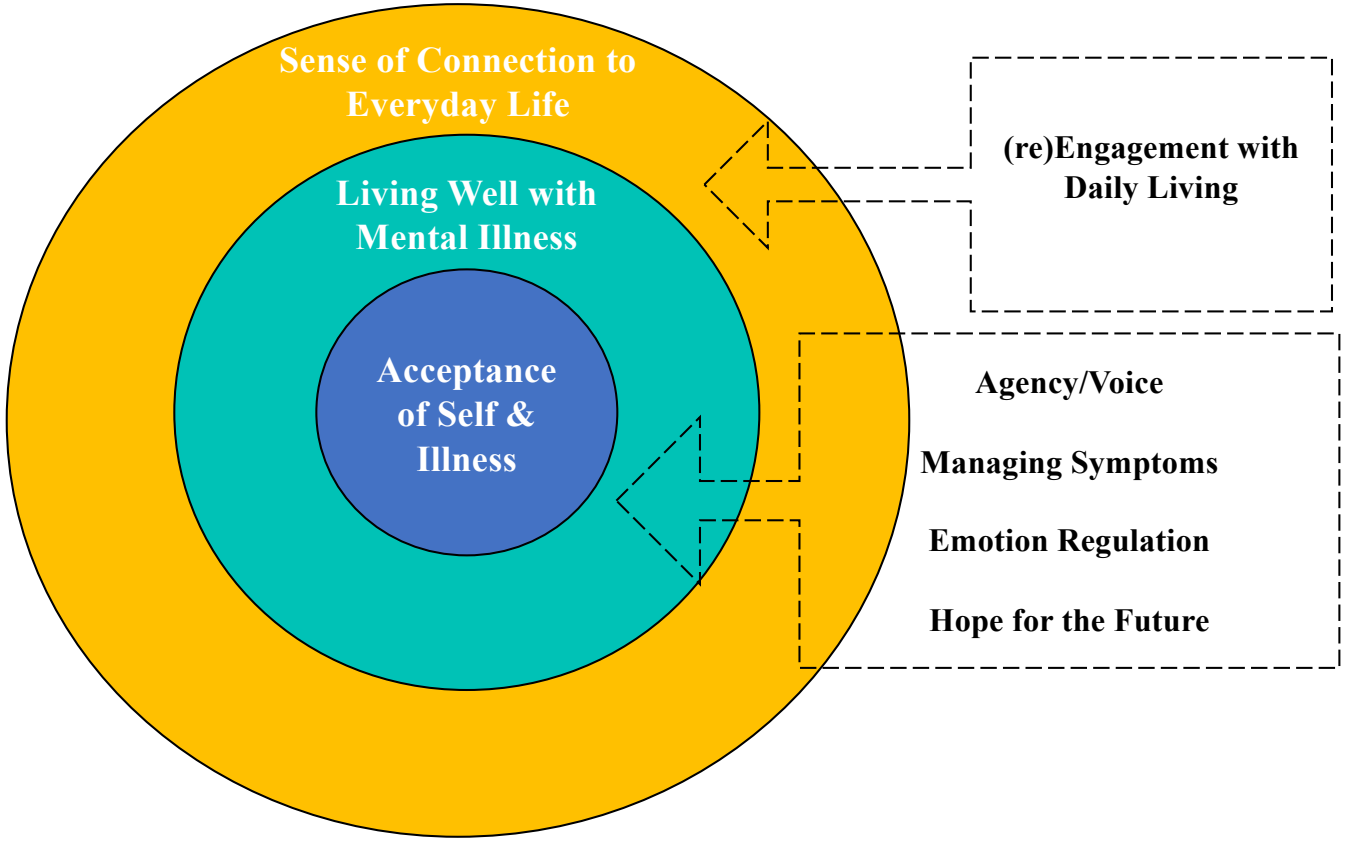
Perhaps of greatest impact on the disconnect from free time activities was the participants disclosed aversion to pleasurable events, as if they felt experiencing positive emotion results in further disappointment.

> *Whenever I get happy, something bad happens and so if I don't get happy then nothing bad will happen and it will be fine. So it's like, do I allow myself to get happy and risk something bad happening or do I stay like this and nothing bad will happen – and I know that's total bullshit but it's also how we perceive it because we already feel so vulnerable" – "totally, yeah!" [agreement from other participants echoed in the*

background]; "What scares me is like, when things do get better and bad things stop happening and I'm not struggling as much as I am now, am I going to be okay with that. This shitiness is what I have come to know.

Figure 4.3 represents the phase one findings that are connected to the content of the BYBS-Y program as the purpose of the program was to begin to shift one's narrative towards strengths, through the exploration of the positive aspects of self.

Figure 4.3 – Youth voice findings related to program content.



Supportive Facilitation

The participants made it clear throughout the focus group that they had an idea of what living-well meant to them, and this created a sense of curiosity surrounding their treatment experiences and led to a discussion that informed the BYBS-Y facilitation (process). A particularly impactful part of the interview was the reactions provoked when asked what was missing in previous programs. The participants focused immediately on the skills and abilities of those who have worked with them suggesting particular traits that support effective mental health workers, rather than the components of the program, supporting perhaps that content is not the most important element of effective treatment. The data supported four subthemes surrounding effective facilitation: (1) honesty/trust; (2) reliability/consistency; (3) authenticity; (4) gratitude.

Honesty/Trust. Honesty/trust are essential aspects of therapeutic relationships. In the phase one focus group the participants provided important insights as to actions that might facilitate their trust. Personalization within a therapeutic relationship was described as a valued aspect for the participants,

> *A good therapist is someone who listens, not just in the office and then forgets about you, someone who is willing to go above and beyond, to remember you like tea and have one there ready for you sometimes. Someone who recognizes that sometimes talking in an office is hard for us and is willing to go on a walk and talk or go to Tim Hortons and get a drink*

For youth, trust is built through action, as this life stage is marked by a particular need for validation. Literature supports that youth seek opportunities for achievement as recognition for such fulfills this developmental need to feel seen (Steinberg, 2019). In the context of therapy, a

sense of visibility was particularly important for one of the participants who described a sense of invisibility when a therapist utilized comparative strategies in a session. *[A good therapist is] "somebody that lets you talk, and doesn't talk over you during the most emotional thing you've ever said or bring up patients who are worse off than you thinking that will make you feel better about your situation – it doesn't, you just feel invisible"*

In BYBS-Y process, honesty/trust involved a focus on sharing mutual respect, so participants could ask for what they needed and discuss how they felt without fear of judgement. It included aspects of accountability with the facilitator's willingness to take ownership of mistakes made within the group so amends could be made, and the establishment of clear professional boundaries.

Reliability/Consistency. Reliability/consistency contribute to the establishment and longevity of effective therapeutic relationships. In the phase one focus group the participants articulated value for follow through suggesting [A good therapist is] "*Someone who comes to see you when you're here, after they've told you they would".* Also connected to reliability was the notion of preparedness, as the participants described how effective therapists should be familiar with case notes prior to seeing a client.

> [A good therapist is] *Someone who doesn't ask me to tell my story over and over again. One of the worst parts of getting help, is having to re-tell my story. I lived it and I've told it to enough people, why can't you just read it on the paperwork that was sent to you ahead of time. What is the point of having a medical file if they aren't going to read it?*

The notion of competence was also discussed in the context of responsiveness. Although indeed the participants held value for honesty, they also voiced needing safe responses from their therapist in order to maintain a sense of security within the relationship. *[A good therapist is]*

"someone who doesn't scare you about what you've experienced by telling you they've never deal with anyone with so many complex traumas, that isn't helpful, it makes you feel like you're a science project."

In the BYBS-Y process, reliability and consistency involved a focus on follow through. The value of following through with what you've told a client you will do involves being aware of one's own strengths and limitations so as to not overcommit to aspects or tasks within a therapeutic relationship, while also maintaining a sense of balance with competing priorities, including but not limited to client caseloads.

Authenticity. Authenticity contributes to the development of trusting relationships that allows transparency between the parties and creates space for vulnerability and growth. In the phase one focus group the participants articulated value for a therapist who was able to attend to the conversation and be present in the moment with them as they spoke, suggesting this strategy helped them feel a greater sense of connection in the sessions. [A good therapist is] *"someone who listens to your problems and doesn't have to write notes about it in front of you, 'cause that makes you want to stop talking, and you wonder what they're writing. And also, somebody who isn't there to talk more about themselves than you are to talk about yourself".* In addition, the participants described value in getting to know who their therapist was, suggesting that a therapist who revealed their 'human side' was more effective than one who was closed off. In fact, the participants discussed self-disclosure as a mirrored behaviour, in that open and honest therapists created more space for them to embody same.

> [A good therapist is] *Someone that you can show your true self to, not just what you choose to show, but who you really are and how you really feel, knowing that they are*

going to be there to help pick up the pieces and they aren't just going to turn around and tell you that you're too screwed up to help and you have to try someone else.

In the BYSB-Y process, authenticity was embodied through the purposeful integration of core values into all thinking, feeling and behaviours which in turn underpinned consistency/reliability and honesty/trust. This practice involved a choice to be real with the participants and sharing examples from personal experiences while acknowledging strengths, fears, challenges and limitations in the context of group discussions and exercises.

Generosity. Brown (2018) coined the term generosity suggesting it involves extending to others the most generous interpretation possible to the intentions, words and actions of your client in an effort to maintain a welcoming positionality with them, especially when feelings of conflict are present. Synonymous with the notion of generosity is the practice of unconditional positive regard, which involves the allowance of space for clients to make mistakes without fear of shame or dismissal (Brown, 2012; 2018). With young people who are struggling with emotion regulation, this strategy is of particular value in a therapeutic relationship. The participants in the phase one focus group described frustration with helping professionals making assumptions about them based on diagnosis, suggesting [a good therapist is] *"someone who doesn't read the labels that someone previously put on you and doesn't assume you're the stereotypical version of whatever your diagnosis is."*

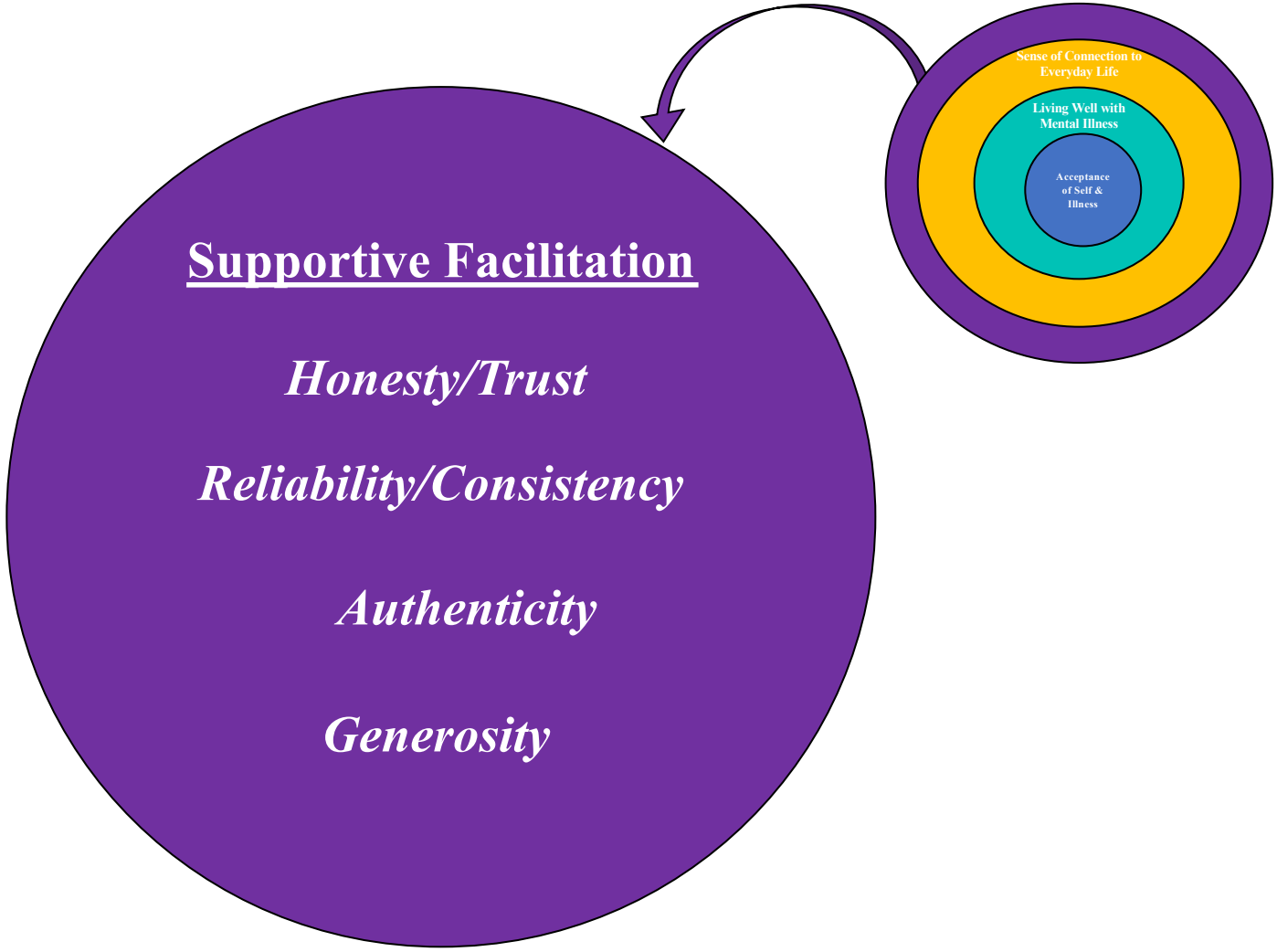
The practice of generosity in therapeutic relationships is about assuming a client is doing the best they can within the circumstance and not assigning value to the experience but rather accepting it as it is, and this process was practiced regularly throughout the BYBS-Y facilitation. Challenge with activation, engagement and dysregulation was anticipated to be part of the

facilitation experience. As such, a commitment to practicing generosity would allow space for the participants to have bad days without becoming alienated from the program.

In the phase one focus group the participants described a history consistent with ineffective interventions which had led to some resistance to helping professionals and skepticism towards services that were available. This unanticipated discussion provided valuable insight surrounding effective facilitation and experiences shared by the participants in phase one. This made it clear that in order to effectively facilitate opportunities for the BYBS-Y participants to engage with program, it would need to be facilitated in a way that set the program apart from previous experiences in therapy.

The supportive facilitation findings further informed the strengths-focus used throughout the program and the thematic change for all activity and summary sheets within the participant workbook. The documents within the program utilized humour and animals as a purposeful representation of the facilitator (Principal student investigator) that would later provide the opportunity for the facilitator to come to life in the treatment space. Figure 4.4 represents the findings that informed this facilitation of the BYBS-Y program and will be discussed further in chapter six.

Figure 4.4 – Findings That Informed Facilitation.



BYBS-Y Program

The "Be Your Best Self" program (BYBS) (Hood & Carruthers, 2016b) is a therapeutic recreation program designed to support individuals living with mental illness in the development of a strengths-based identity. The BYBS program was developed in 2013 for use within the adult mental health population. The BYBS (adult) program has been run more than two dozen times in outpatient psychiatry at a local hospital, with anecdotal evidence supporting the effectiveness of the program. Formal research measuring the effectiveness of the BYBS (adult) program is currently in process.

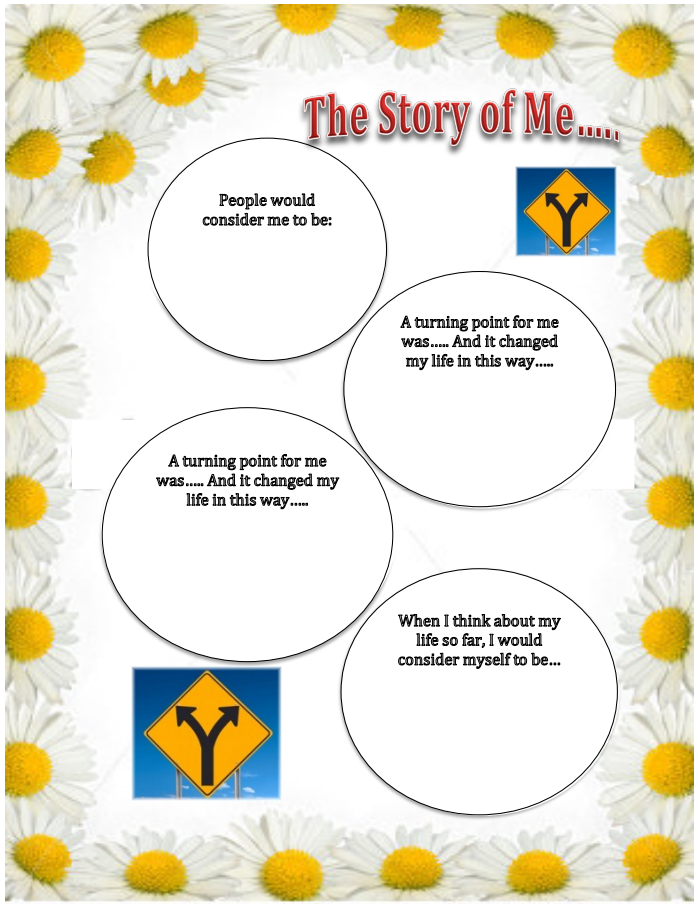
Ego development is considered to be the overarching task of the adolescent life stage, as it supports a successful shift to becoming autonomous (Erikson, 1959). As such, focusing on a balanced narrative, that includes mental illness but is not defined by it, seems to be of particular value to the youth accessing residential mental health treatment services. The BYBS program in its original form included a total of twelve sessions that were offered once weekly for 90 minutes each. Based on the pragmatics of community-based research, consultation with the local partnering agency was sought before determining the administrative changes to the program. Using agency feedback, the decision was made to implement BYBS-Y as an intensive program in order to minimize the disconnect between sessions. The shift to an intensive program mandated that some of the sessions from the original BYBS program be eliminated. These preliminary decisions were informed by the clinical experience of the primary researcher, agency recommendations, and insights gained from the literature review. Table 4.5 illustrates a comparison of the original adult-oriented BYBS program and the revised program for youth, as informed by phase one.

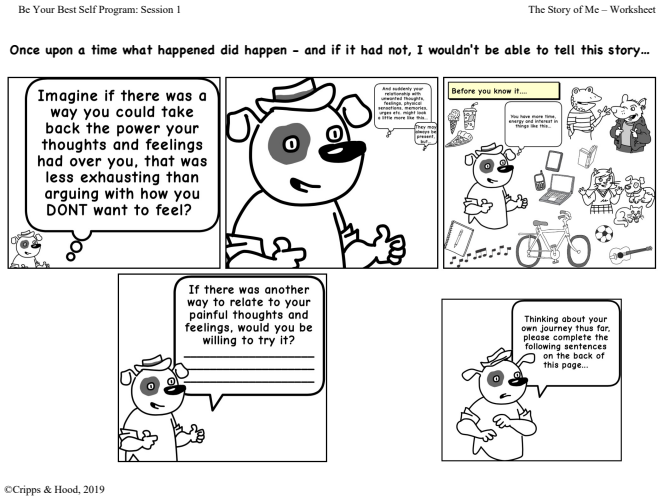
Table 4.5 – Comparison of Original and Revised BYBS Program

Be Your Best Self – Original (Hood & Carruthers, 2016b)	**Be Your Best Self – Youth Revision**
Understanding Narrative	Understanding Narrative
1. Introduction to Narrative	1. Introduction to Narrative *and Acceptance*
2. Looking at Both Sides of the Story	2. *The Tree of Life – Looking at both sides of the story*
Discovering Strengths	Discovering Strengths
3. Incorporating Strengths into Your Story	3. Incorporating Strengths into Your Story
4. Multiple Intelligences	4. Strengths! Multiple Intelligences & Colours of Personality
5. Colors of Personality	5. Discovering Strengths through Leisure
6. Discovering Strengths through Leisure	
Using Strengths	**~~Using Strengths~~**
7. Examining Leisure Interests	
8. Using Leisure to Express and Develop Strengths	
Creating Strengths-Based Narratives	Creating Strengths-Based Narratives
9. Creating Strengths-Based Alternative Stories	6. Creating Strengths-Based Alternative Stories
10. Setting Values Based Goals	7. Turning Lemons into Lemonade
11. Turning Lemons into Lemonade	8. Wrapping it all up!
12. Putting It All Together	

Aside from the above content changes, there were changes made to the exercises and content summary handouts that would make up the participant workbooks. The changes to such documents were informed by the phase one focus group findings. The phase one participants articulated value in the humanization of the helping professionals they worked with, supporting the opportunity to know things about their therapists which facilitated the establishment of a more trusting relationship. The translation of this finding supported a shift from the "daisy" theme of the original BYBS program to an "animal" theme. Figures 4.6 to 4.8 provide examples of changes made to exercise and summary pages from sessions one and two of the BYBS program.

Figure 4.6 – Session One Worksheet Changes





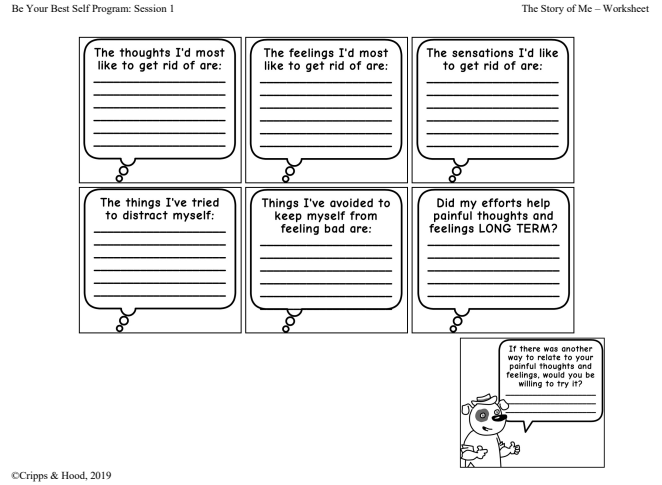


Figure 4.7 – Session One Handout Changes

Our Life Story

"Life hangs on a narrative thread. This thread is a braid of stories that informs us about who we are and where we come from and where we might go." (Anne Pellowksi, 1977)

- Being human involves creating meaning and using language to shape personal experiences into stories, or *narratives.*
- The sense of having a personal identity starts with the act of storying our experiences in the world so that they can be shared with others and reflected on for new self-understanding.
- When we become narrators of our own stories, we produce a sense of self that joins us with others and permits us to look back selectively to our past and shape ourselves for the possibilities of an imagined future.
- We have stories that we tell about specific events in life (*micro-narrative*) and we have the overall story of our life which is made up of a series of smaller stories. This larger narrative is referred to as *self-narrative*.

- Turning points are defined as a perceived, long-lasting redirection in the path of a person's life.
- Turning points can occur as a result of significant life events (diagnosis, change in personal circumstances, significant life achievement or loss) or they may occur more slowly over time as a result of personal reflection and meaning making.
- Turning points involve a major transformation in views about the self, identity, or the meaning of life.

The way we tell the story of our life and the way we look at turning points can determine our ability to move forward life with hope and positivity.

Be Your Best Self YOUTH: Session 1

Our Life Story…

"Life hangs on a narrative thread. This thread is a braid of stories that informs us about who we are and where we come from and where we might go." (Anne Pellowksi, 1977)

- Being human involves creating meaning and using language to shape personal experiences into stories, or *narratives.*
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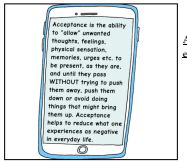

Acceptance helps to reduce what one experiences as negative in everyday life

The process of acceptance focuses primarily on the feeling aspect of experiences

The way we tell the story of our life and our ability to practice acceptance can determine our ability to move forward life with hope and positivity!

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Be Your Best Self YOUTH: Session 1

Strategies for Acceptance:

1. Letting feelings or thoughts happen without the impulse to act on them.
2. Observe your weaknesses but take note of your strengths.
3. Give yourself permission to not be good at everything.
4. Acknowledge the difficulty in your life without escaping from it or avoiding it.
5. Realize that you can be in control of how you react, think and feel.

9

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Figure 4.8 – Session Two Handout Changes

Reconstructing our Dominant Stories

- Life stories connect a series of events in a meaningful way and shape our perceptions of ourselves and of future events.
- We all have many stories about our lives and relationships, occurring simultaneously.
- We have stories about ourselves, our abilities, our struggles, our competencies, our actions, our desires, our relationships, our work, our interests, our conquests, our achievements, our failures. The way we have developed these stories is determined by how we have linked certain events together in a sequence and by the meaning we have attributed to them.
- A **Dominant Story** is one in which certain experiences are privileged over others – like highlighting a story. What we choose to highlight influences the way we see ourselves and our willingness to undertake challenges in the future.
- An **Alternative Story** is another version of the same experience with different parts emphasized or highlighted.

What is your dominant story of yourself and your mental illness? What might be an alternative story?

Be Your Best Self: Session 2

Reconstructing our Dominant Stories

- Life stories connect a series of events in a meaningful way and shape our perceptions of ourselves and of future events.
- We all have many stories about our lives and relationships, occurring simultaneously.
- We have stories about ourselves, our abilities, our struggles, our competencies, our actions, our desires, our relationships, our work, our interests, our conquests, our achievements, our failures. The way we have developed these stories is determined by how we have linked certain events together in a sequence and by the meaning we have attributed to them.
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- An **Alternative Story** is another version of the same experience with different parts emphasized or highlighted.

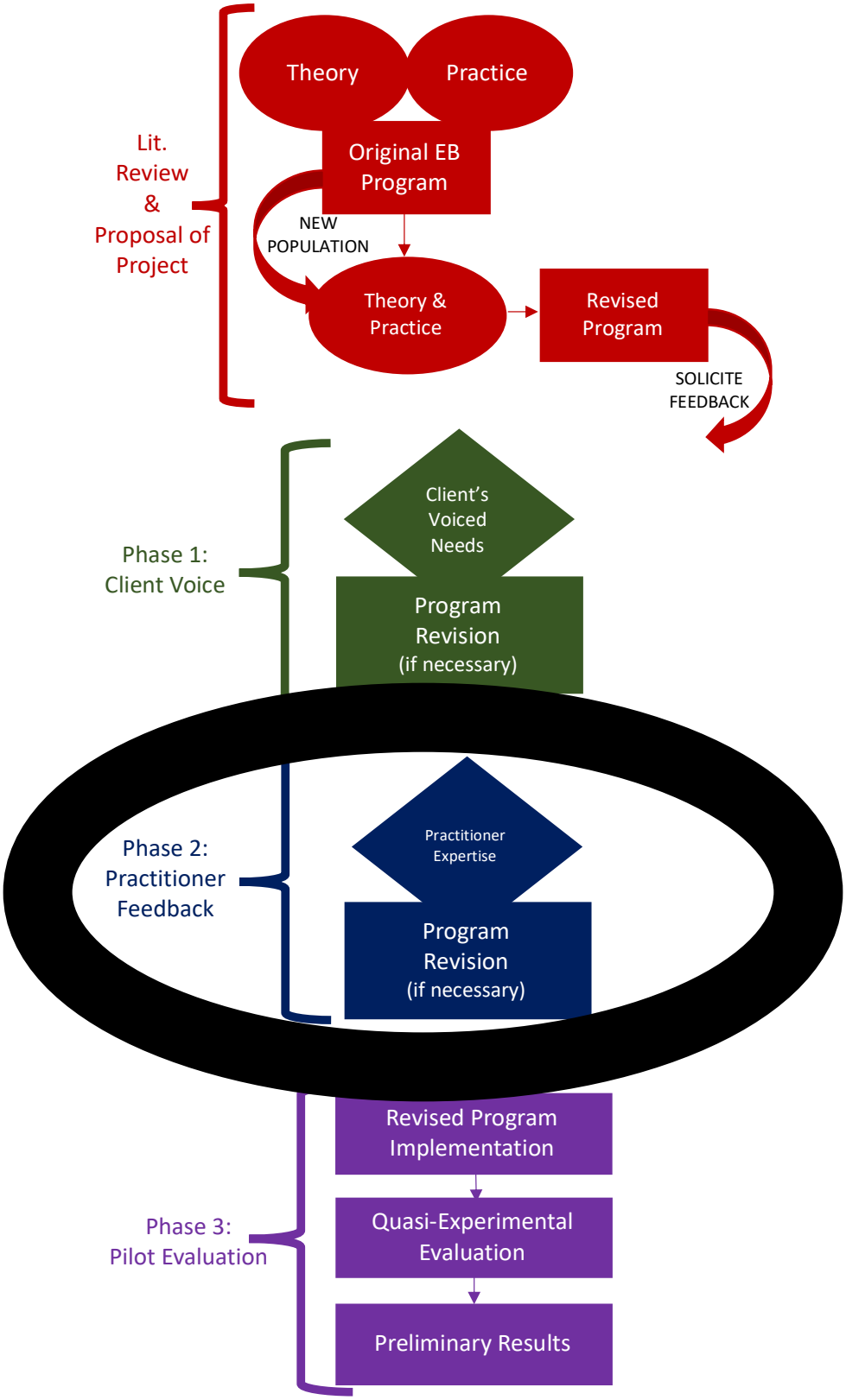
What is your dominant story of yourself and your mental health? What might be an alternative story?

Chapter 5 – Phase Two Results: Clinical Expertise

Participants

This phase was designed to solicit feedback from three to four TR practitioners who had a minimum of six months of employment experience working front line in adolescent mental health. The professional practice lead for TR services was the initial point of contact with a total of 10 agencies in Canada and the United States being sent the letter of invitation, informed consent and a copy of the survey. As per REB clearance, practitioners were not required to contact the principal student investigator prior to participation, consent was assumed upon return of the questionnaire. A total of five responses were received from practitioners, four of whom resided in the United State and one of whom resided in Canada. The minimum level of completed education disclosed by the participants was a bachelor's degree and with two participants indicating the completion of a master's degree. Years of experience in adolescent mental health was requested on the questionnaire with years ranging from 2.5 to 15 years within the population, and total years of employment in therapeutic recreation services ranging from 2.5 to 36 years. Figure 5.1 provides a visual reference for locating phase two within the EIP process.

Figure 5.1 – Locating Phase 2 in the Evidence-Informed Process



Phase Two Participant Feedback Form

Participants provided feedback responses for each of the eight BYBS-Y sessions using a standardized one-page form that included the session summary and goals. The participants were asked to provide an overall score that represented the value of the session and to provide any comments they felt would be relevant. Figure 5.1 represents the form distributed to participants in phase two.

Figure 5.2 – Phase Two Participant Feedback Form

Program Feedback Form

Instructions:
Please review the brief description of the session listed below and rank the value you think it holds for youth facing mental health challenges from 3 to 1 based on your professional opinion. Your written feedback is welcomed and valued for all sessions, if you so wish to dedicate your time. Please note: *Written feedback should be provided for sessions ranked with 1's.*

3= Excellent, topic is very relevant to youth	2 = Good, topic has some relevance to youth	1 = Needs improvement, the topic of the session lacks relevance, written explanation will be provided.

Session #	Session Title: *(TITLE FOR EACH SESSION WAS INCLUDED HERE ON EVERY FORM)*	3	2	1*
Description:	The purpose of this session is ____ (*PURPOSE STATEMENT FOR EACH SESSION WAS INLCUDED HERE ON EVERY FORM)* Session Goals: (*GOALS FOR EACH SESSION WERE INCLUDED HERE ON EVERY FORM)* 1. To facilitate ___ 2. To facilitate ___ 3. To facilitate___			
Comments: ***Written feedback is required for any sessions scored as "1"**				

Findings

The following is a breakdown of each of the eight sessions outlining the quantitative and qualitative data collected on the participant feedback forms. Further discussion of the feedback as it related to program changes will be provided in the next chapter.

Session 1

The following description of session 1 was provided on the participant feedback form for practitioners to evaluate:

Title: Introducing Narrative and Acceptance
The purpose of this session is to introduce clients to the program, to each other, and to the general concept of narrative. In addition, it is important in this session to engage clients in the idea of shifting narrative so that they will want to continue in the program.

Session Goals:
To facilitate understanding of the purpose and expectations of the Be Your Best Self Program.
To facilitate understanding of the concepts of life story and narrative.
To facilitate understanding of the concept of acceptance.

This session was one of four that did not receive a perfect score from the evaluating practitioners. With a sample count of 5, the mean score was 2.8. The range for this session was 1, with a minimum score of 2 and a maximum score of 3.

There were only two responses in the open-ended "comments" section of the questionnaires. The first comment validated the impact of this session specifically connected to the third goal articulated in the program description, *"I always think the first session of any program should be 'knowledge'. Youth struggle with 'self-acceptance' due to many factors but having a program/session focus on such is a good idea (and is needed)."* – Participant 1. The meaning of the second feedback comment was somewhat unclear to the primary researcher "Add a descriptor of the Be Your Best Self Program; reference to information" Participant 2. It was questioned whether this comment was in relation to the participant's desire to have more

information on the program evaluation form, or their suggestion that there should be a description of the BYBS program in the first session.

Session 2

The following description of session 2 was provided on the participant feedback form for practitioners to evaluate:

Title: Tree of life part 1 – Looking at both sides of the story
The purpose of this session is to encourage clients to consider dominant and alternative stories and the impact of how they think about their own life experiences. In addition, clients will experience the process of identifying how illness or disability affects them (dominant story of limitation) and how they can start to look for alternative aspects of the story (strengths discovered as a result of challenge).

Session Goals:
To facilitate understanding of the concepts of dominant and alternative stories.
To facilitate awareness of strengths associated with illness/challenge.

This session was also among the four that did not receive a perfect score from the evaluating practitioners. With a sample count of 5, the mean score was 2.8. The range for this session was 1, with a minimum score of 2 and a maximum score of 3.

There were three responses in the open-ended "comments" section of the questionnaires. Participant 2 *iterated "I'm not familiar with 'dominant and alternative stories' but within the context of the program I think I understand. I like how one will be encouraged to focus on their life story as a whole and how certain areas/circumstances may have/has had an impact on their current state of well-being"* while the remaining comments challenged the session. Participant 3 echoed similar thoughts while questioning the concepts based on population, *"I think exploring the strengths-based side of stories would be greatly beneficial while also acknowledging how their illness affects them. Processing wise I wonder if adolescents might have difficulty if they're rigid in their thought process."* Difficulty with the session was also expressed in the final

comment *"In my opinion, this session will require a lot of abstract thinking and individuals with a lower IQ or individuals who can only think in terms of concrete thoughts might struggle without assistance"* – Participant 4.

Session 3

The following description of session 3 was provided on the participant feedback form for practitioners to evaluate:

Title: Tree of life part 2 – Incorporating strengths into your story
The purpose of this session is for clients to complete the second half of the tree of life activity (started into previous session). In addition, clients will begin to explore (brainstorm) what strengths are and why they are important to identity.

Session Goals:
To facilitate understanding of the concepts of strengths.
To facilitate awareness of the benefits of using strength in daily life.
To facilitate awareness of personal strengths.

Session 3 was among the four that were best received as reflected by the perfect score from the evaluating practitioners. With a sample count of 5, the mean score was 3. The range for this session was 0, with a minimum and maximum score of 3.

The open-ended feedback received on this session further supported the perfect numerical value assigned. Participant 1 wrote "*Promoting self-esteem through acknowledging strengths is greatly beneficial with adolescents*". Participant 2 suggested reordering sessions, *"Session Two and Three Switch – help the youth identify their positives first. Starting with focus on own life experiences, as many have been negative and/or traumatic may contribute to not being able to find and/or struggle to find strengths, own sense of worth"*. Finally, participant 3 wrote *"Anytime a clinician works on acceptance I think personal strength should be discussed. One can implement/focus on strengths to overcome personal and past challenges".*

Session 4

The following description of session 4 was provided on the participant feedback form for practitioners to evaluate:

Title: Strengths! Exploring the Multiple intelligences and colours of personality
The purpose of this session is for clients to understand the theory of and evaluate the results of their multiple intelligences scale and colours of personality scales. In addition, clients will be given the opportunity to connect these results back to activities which might support highlighting their strengths.

Session Goals:
To facilitate awareness of multiple intelligences
To facilitate awareness of colours of personality
To facilitate awareness of personal areas of strengths

Session 4 was the third of four that did not receive a perfect score from the evaluating practitioners. Calculating consistently with sessions one and two, session four had a sample count of 5, and a mean score of 2.8. The range for this session was 1, with a minimum score of 2 and a maximum score of 3.

There were three open-ended comments made for this session, the first suggesting that the amount of content was over ambitious. *"Split this to more than one session. Having done similar exercises, the focus on each identified goal area and application generally exceeds the time provided – in a good way"* – Participant 2. The second comment validates the content based on practitioner experience in relation to acceptance, *"This is a good way to make the learning of acceptance (and personal strength) fun. Although colors can represent ones self- this is not always the case and can change day to day. (I've used something similar to this and every time the youth seem interested)"* – Participant 3. The final comment confirmed the succession of the session as it relates to the scaffolding between sessions four and five of the program, *"Is there a*

way to link the colours of personality and the multiple intelligences to the leisure activities as well?" – Participant 4.

Session 5

The following description of session 5 was provided on the participant feedback form for practitioners to evaluate:

Title: Discovering your strengths through looking at leisure

The purpose of this session is for clients to understand what leisure is, and the value it holds. In addition, clients will have the opportunity to connect personal strengths to preferred leisure activities.

Session Goals:
To facilitate awareness of the concept of leisure
To facilitate awareness of personal strengths associated with preferred leisure activities

Session 5 was the second of four to receive a perfect score from the evaluating practitioners. With a sample count of 5, the mean score was 3. The for this session was 0, with a minimum and maximum score of 3.

There were three open-ended comments made for this session. Two iterated critical considerations *"Add identification of what leisure/recreation activities actually are. Generational, location, culture variances"* – Participant 2 and *"Is there a way to link the colours of personality and the multiple intelligences to the leisure activities as well?"* – Participant 4. The third comment validated the strength of the session *"This is what RT is all about. Well-being and acceptance through meaningful and fun activities"* – Participant 3.

Session 6

The following description of session 6 was provided on the participant feedback form for practitioners to evaluate:

Title: Creating strengths based alternative stories
The purpose of this session is to begin to describe their best self, through highlighting the strengths and capacities previously discussed and support the development of a "strengths based alternative story".

Session Goals:
To facilitate awareness of the role of alternative stories in living well
To facilitate understanding of the concept of best life possible
To facilitate awareness of the importance of thinking about what one wants their life to look like

Session 6 was the final session that did not receive a perfect score from the evaluating practitioners. With a sample count of 5, the mean score was 2.8. As with previous sessions, the range for this session was 1, with a minimum score of 2 and a maximum score of 3.

The open-ended comments for this session were as follows, *"A creative portion, or narrative/discussion only? Provide opportunity for a hands on 'take with' lesson"* – Participant 2; *"I think this is good for youth, so they can to stop and think about how they want their future to look and what changes need to be made to fulfill their future goals and they can do this by thinking of the past sessions completed"* – Participant 3*; "In my opinion, this session will require a lot of abstract thinking and individuals with a lower IQ or individuals who can only think in terms of concrete thoughts might struggle without assistance"* – Participant 4.

Session 7

The following description of session 7 was provided on the participant feedback form for practitioners to evaluate:

Title: Making lemonade out of lemons
The purpose of this session is to give clients the opportunity to understand the role of growth as a result of challenge. This session connects back to acceptance of circumstance and the development of hope for the possibility that something good can result from challenge.

Session goals:
To facilitate awareness of the definition of post traumatic growth (PTG)
To facilitate awareness of self-discoveries arising from difficult life events

Session 7 was the third of four to receive a perfect score from the evaluating practitioners. With a sample count of 5, the mean score was 3. The range for this session was 0, with a minimum and maximum score of 3.

There were two open-ended comments provided for this session; the first validating the focus *"Every youth I have worked with has experienced some sort of trial (hardship) (big or small) and educating them on how to make something positive from negative is much needed"* – Participant 3. The second comment recommended a learning activity, *"Be fun to make lemonade; varying levels of sweetener; a sensory exploration of how strengths vary"* – Participant 2.

Session 8

The following description of session 8 was provided on the participant feedback form for practitioners to evaluate:

Title: Wrapping it all up!
The purpose of this session is to review the process of the program and connect the sessions together. This session will provide clients with the opportunity to explore the overarching concepts of the program and summarize what they have learned.

Session Goals:
To facilitate awareness of the scope of the Be your best self-program
To facilitate the ability to summarize what has been learned

Session 8 is the final session of the BYBS program and the fourth to receive a perfect score from the evaluating practitioners. With a sample count of 5, the mean score was 3. The range for this session was 0, with a minimum and maximum score of 3.

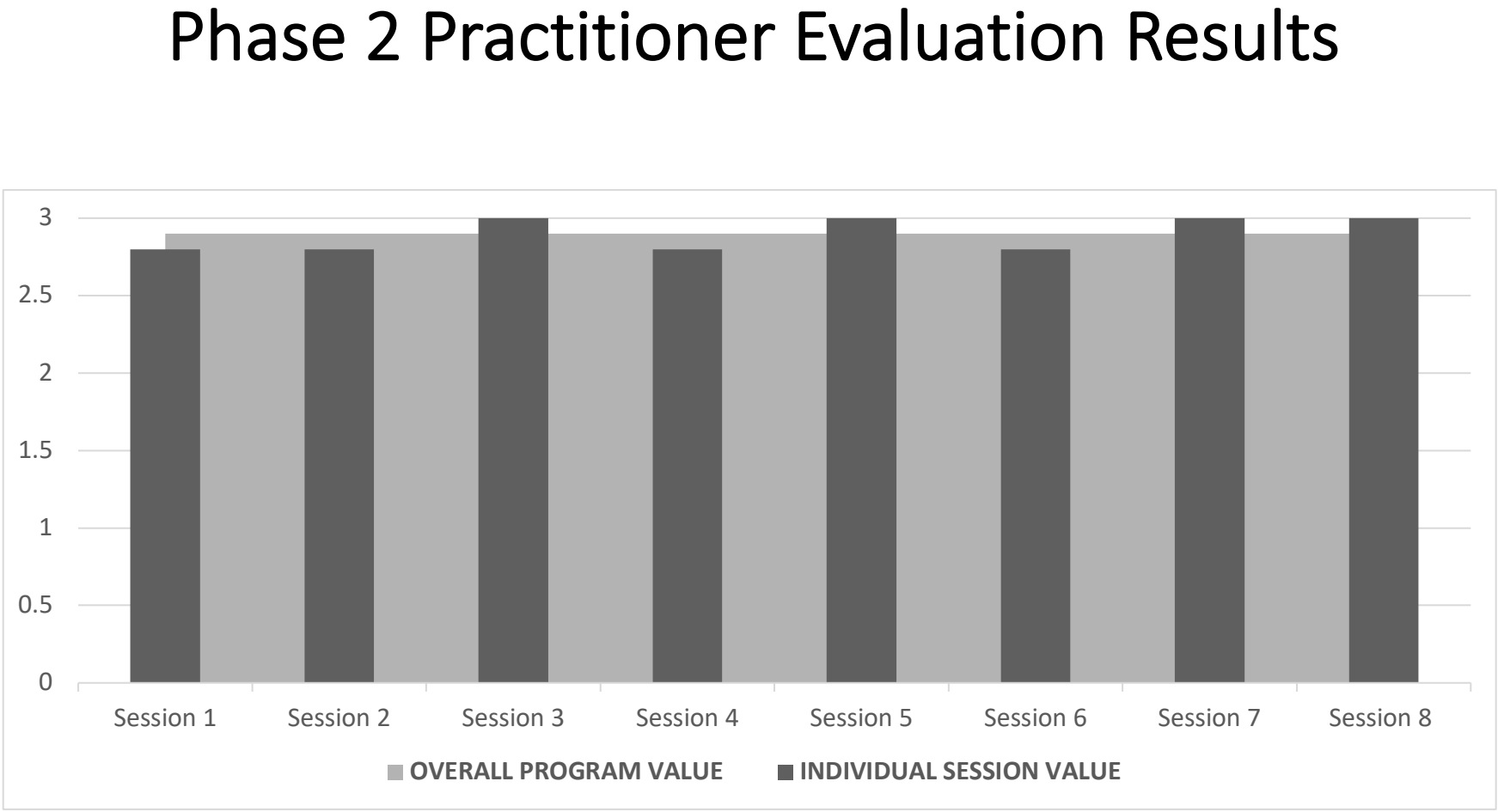
Four of the five participants provided open-ended responses in the comments section for this session. The comments ranged from overall impression to critical implications of the session. Participant 3 iterated *"I like how each session is built upon the others. I would suggest*

possibly moving session 7 with session 6 so they can then think of their full life story and how they can work towards their future regardless of their past. This program follows the 'knowledge, skill, and ability' guidelines where they are educated each session, learn skills needed to be successful and then implement them into the activity/discussion". Participant 4 explored some clinical considerations for the program *"This is going to be very important for the Evaluation and Documentation portion of the APIED process. But also, make sure that at the end of all the sessions that there is a review or debriefing part of the session. Also, is there a Pre-session that will determine which individuals will receive this eight-course session?"* Participant 1 questioned the need for an additional session, *"Might be a good idea to also add goals to this session. You've learned this information so how can you make it applicable"*, while Participant 2 brought attention to takeaway materials *"Will they have a scrapbook/journal; a gathering of materials to keep, refer back to?"*.

Participant Feedback Results

The results from phase two were encouraging with five participants each evaluating eight sessions each, the overall sample count was 40. The overall mean feedback score was 2.9 from the evaluating practitioners, and the range for the program was 1, with a minimum score of 2 and maximum score of 3. Figure 5.3 summarizes the results of this phase.

Figure 5.3 – Phase Two Practitioner Evaluation Results



Overall Practitioner Evaluation Scores	
Mean	2.9
Range	1
Minimum	2
Maximum	3

Chapter 6 – Phase Three Results: Pilot

Recovery with mental illness is described as a process through which individuals with mental illnesses develop capacities related to living a full and meaningful life, in spite of experiencing ongoing symptoms or challenges related to illness. One central tenet of recovery is the development of a positive identity that is inclusive of mental illness but not defined by it. The "Be Your Best Self" program (BYBS) (Hood & Carruthers, 2016b) is a therapeutic recreation program that focuses on positive identity development and narrative reconstruction. The BYBS-Youth (BYBS-Y) program is an adaptation of the original adult program and used an evidence informed framework described previously to inform this process. The BYBS-Y program was adapted for and implemented twice weekly (Mondays and Thursdays 6-7:30pm) at a residential treatment facility from March 18, 2019 through April 15, 2019. A post-program focus group was conducted on Thursday April 18, 2019 with the program participants. The findings from this phase will outline the quantitative data (descriptive statistics) generated from the pre and post assessments, as well as the qualitative data from the post program focus group.

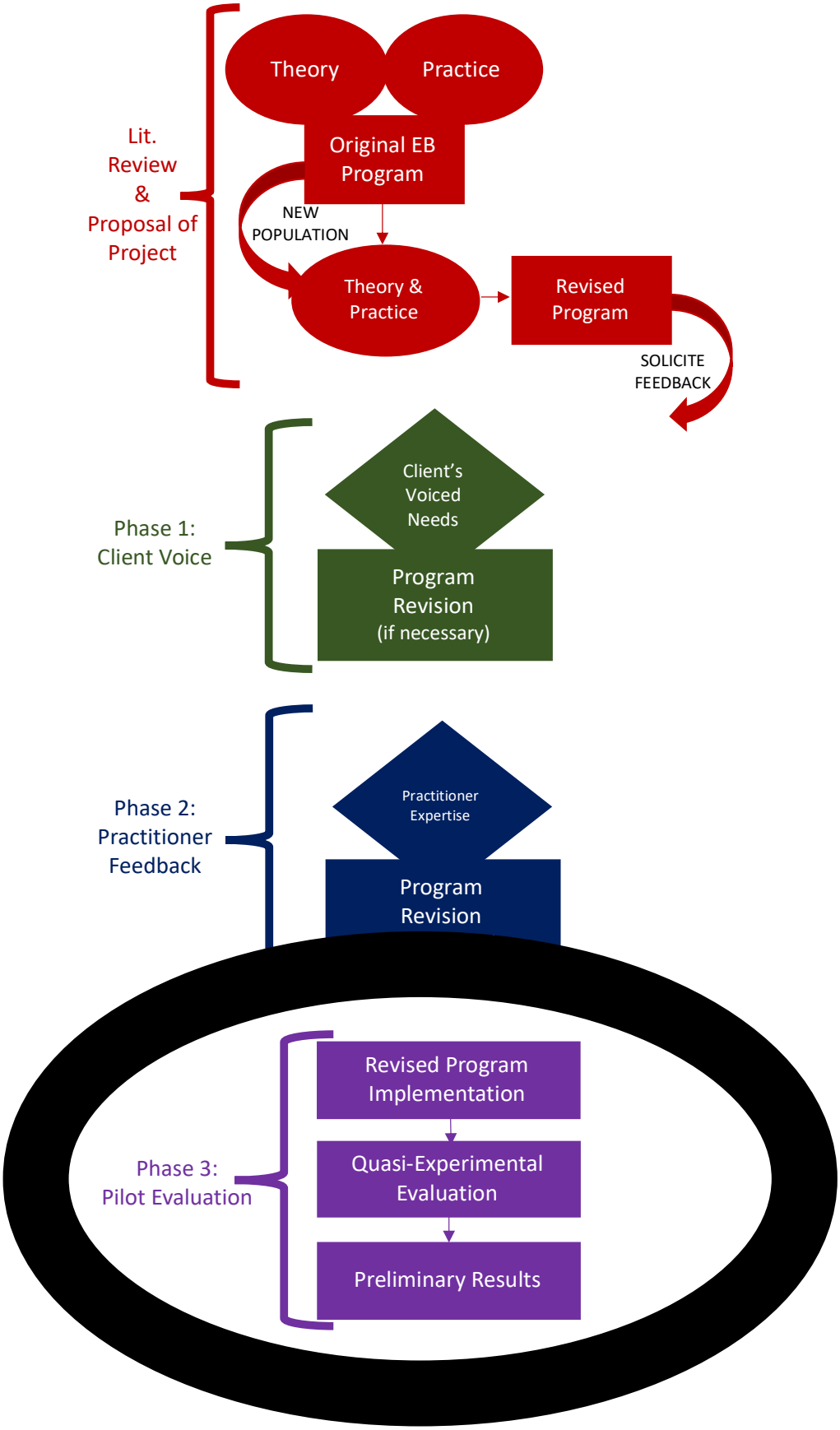
Phase three was designed to evaluate the impact of the BYBS-Y program on clients' recovery, well-being, sense of self, and mental health. Figure 6.1 provides a visual reference for locating phase three within the EIP process.

Phase 3 sub-research questions.

1. How does engagement in the BYBS program impact recovery, well-being, and mental health?

2. What aspects (sessions, learning activities) of the BYBS program are identified by the participants as being most impactful to their sense of self?

Figure 6.1 – Locating Phase 3 in the Evidence-Informed Process



Participants

The Be Your Best Self program was scheduled into the evening schedule as regular programming for all of the clients living at the residential treatment facility during the 5-week implementation. There was a total of 9 youth who participated in sessions of the BYBS program however data collected were only from a total of six participants in the program with 2 complete data sets and four partial data sets. The participants once again ranged in age from 14 to 17 years of age. Participant consent was collected prior to the data being analyzed at the end of the program. Three of the participants self-identified as female on the informed consent and two participants self-identified as male (transgender, transitioning to).

Process Evaluation

The following is a discussion, session by session, of the facilitation experience. This discussion is informed by the session observation notes made by the program observer (research assistant), and the post-session field notes and journals maintained by the primary investigator throughout the five weeks that spanned program implementation. At the end of sessions the participants also completed a 5 question social validation questionnaire (Foster & Mash, 1999) in which they indicated their perceptions of the importance of the topic, their sense of improvement in the skills related to the topic, and their confidence that they will be able to use the skills and concepts in their lives outside of the program. The results of the social validation questionnaires will also be included in the discussion.

Pre-program assessment visit

The first visit to the facility took place on Monday, March 18, 2019. During this visit the youth living within the facility had the opportunity to meet the facilitator and complete the following assessments: The COMPAS-W Scale of Well-Being (Gatt, Burton, Schofield, Bryant,

& Williams, 2014); selected subscales of the Wellness Evaluation of Lifestyle (Myers, Sweeney, & Witmer, 2004); the Adolescent Mental Health Continuum – Short Form (A-MHC-SF) (Keyes, 2008); and the Stages of Recovery Inventory (STORI-30) (Andresen, Caputi, & Oades, 2006). The participants were all able to complete the assessments with minimal assistance. The scales were collected and stored in the individual participant folders for future analysis.

Individual Session Results

Session 1. The purpose of session one was to introduce clients to the program, to each other, and to the general concept of narrative. In addition, a key focus for this session was to gain participant buy-in with the idea of shifting narrative in order to pique their interest for the subsequent sessions. The first session was very well received. The participants were engaged but quiet for the first part of the session as we discussed the rules and expectations of the group. Despite having already done so upon admission to the facility, the participants were required to sign confidentiality agreements as part of the administrative paperwork at the beginning of session one. This was done in an effort to establish a safe environment at the outset of the program, as trust and safety were identified needs supported by the phase one findings. The "same song different feeling" activity utilized two different versions of the song Shallow from the popular movie A Star is Born. The same song different feeling activity was quite successful, resulting in several participants getting up and dancing during the second, more upbeat version of Shallow. The discussion generated after the activity demonstrated a clear understanding of the purpose, and the clients were able to connect the notion to their current circumstance with minimal prompting. By the end of the session all participants had completed their story of me worksheet and social validation measure. There was minimal difference between practitioner and youth importance scores for session one, supporting the effectiveness of session one overall.

Table 6.2 - Session 1 social validation scores

Session 1 Social Validation Scores			
	Importance	Skills	Usability
Mean	4.28	3.83	3.83
Minimum	1.00	1.00	2.00
Maximum	5.00	5.00	5.00
Number of respondents: 6			

Six social validation scales were collected at the end of session one. With a mean score of 4.28 out of a possible 5, the participants felt strongly towards the overall value of the topic. There was a maximum range for this session (4.00) suggesting that there was at least one participant that did not feel the session held much topical importance, however, based on the mean score, the majority of the participants did. With regards to their sense of improvement in the skills related to the topic, the participants indicated a feedback mean score of 3.83. There was a maximum range of 4.00 with regards to skills, which suggests there was also at least one participant who felt that the session did not provide them with improved skills. With regards to their confidence that the skills and concepts are usable in their lives outside of the program, the participants also indicated a feedback score of 3.83. The range was 3.00 which suggests that none of the participants indicated the skills usability of the session was null.

Session 2. The purpose of session two was to encourage participants to consider dominant and alternative stories and the impact of how they think about their own life experiences. In the session the participants had the opportunity to explore the process of identifying how illness or disability affects them (dominant story of limitation) and how they

might start to look for alternative aspects of the story (strengths discovered as a result of challenge).

Each session began with a recap of the previous session. In this session the participants were able to recall the same song different feeling activity with minimal prompting. The focus of session two was life stories and was facilitated through group discussion and the tree of life activity. The discussion focused on the impact of illness, including challenges and strengths. The participants appeared to be engaged and were verbally responsive when discussing challenges but struggled with verbalizing strengths. The facilitation of the tree of life activity was difficult with the group, they struggled to follow instructions and required ongoing redirection. The space was quite noisy during the activity and side conversations were noted. The participants completed part one of the tree of life activity, as outlined in the program plan, but voiced feelings of frustration and lack of enjoyment at the end of the session. By the end of the session, the participants were not able to verbalize their strengths without support from the facilitator.

Interestingly, the social validation score on session two was slightly higher than the practitioner feedback score. In the post program focus group, the participants once again voiced revamping this session and removing the tree of life activity, however they also articulated value in the discussion portion of the session, which may account for the high feedback score. In phase two, the practitioner feedback questioned the client's ability to grasp the abstract thinking required to complete the activity. This insight proved to be valuable as, indeed, the activity was problematic for the group. Overall the focus of the session appears to be valuable to the participants, but the learning activity requires further consideration.

Table 6.3 - Session 2 social validation scores

Session 2 Social Validation Scores			
	Importance	Skills	Usability
Mean	4.73	4.20	4.20
Minimum	4.00	3.00	3.00
Maximum	5.00	5.00	5.00
Number of Respondents: 5			

Five social validation scales were collected at the end of session two. With a mean score of 4.73 the participants felt strongly towards the overall value of the topic. The range was 1.00, suggesting that all of participants that felt strongly about the importance of the topic.
With regards to their sense of improvement in the skills related to the topic and the participants' confidence that the skills and concepts are usable in their lives outside of the program, the participants generated identical scores. The response range was 2.0, which suggests that none of the participants indicated that neither the skills nor usability of the session were null.

Session 3. The purpose of session three was for participants to complete the second half of the tree of life activity (started in session two), however, after experiencing great challenge with the activity in the previous session, participants were given the option to complete an alternative strengths seeking activity in an effort to familiarize them with strengths based language. The participants unanimously chose the alternative activity and the tree of life from the session two was left incomplete. Following the strengths-language activities, the participants were given the opportunity to begin to explore (brainstorm) what strengths are (in general) and why they might be important to identify.

Session three began with a recap of the tree of life activity, which led to a discussion on the challenges of the activity. The feedback received from the participants indicated challenges with on the spot thinking and too much preoccupation with the artistic aspect of the activity. As a result of the noted challenges at the end of session two, an alternate plan for session three was

developed. Following the completion of the strengths-knowledge scale, the participants were given the option to complete the tree of life activity or complete an alternate activity. There was a unanimous vote for the alternate activity which further supports the need to eliminate the tree of life activity from the program. In lieu of completing the tree of life, the participants were given several "strengths" language activities to familiarize them with strengths language. The alternate activities were completed independently and a group discussion on fixing weaknesses versus building strengths was then facilitated. The participants were shown two brief videos regarding the negativity bias and neuroplasticity, which were both noted as well received.

By the end of the session the participants were able to verbalize an understanding of strengths and the benefits of using strengths, when prompted. Prior to the session completion the participants completed the social validation measure for session three. The clients also completed multiple intelligences and colours of personality scales in preparation for the next session prior to leaving the treatment space. The social validation and practitioner feedback scores represent minimal difference which supports the effectiveness of session three overall.

Table 6.4 - Session 3 social validation scores

Session 3 Social Validation Scores			
	Importance	Skills	Usability
Mean	4.53	4.80	4.80
Minimum	2.00	4.00	4.00
Maximum	5.00	5.00	5.00
Number of Respondents: 5			

Five social validation scales were collected at the end of session three. With a mean score of 4.53 the participants felt strongly towards the overall value of the topic. The range was 3.0, suggesting some variation in the feedback, with none of the participants indicating topical irrelevance. With regards to their sense of improvement in the skills related to the topic and the participants' confidence that the skills and concepts are usable in their lives outside of the

program, the feedback generated identical scores. The mean for both was 4.80 and the range was 1.0, which suggests the participants felt strongly about the improvement and usability of skills from this session.

Session 4. The purpose of session four was for participants to understand the theory of and evaluate the results of their multiple intelligences and colours of personality scales. In addition, the participants were given the opportunity to connect the results back to activities which might support highlighting their strengths.

Session four began with a recap of the previous session during which participants were able to verbalize the value of strengths using appropriate language with minimal assistance. Session four focused on the interpretation of multiple intelligences and colours of personality measures. The assessments for each were completed by the participants at the end of session three and the results were calculated by the facilitator prior to the start of session four. Overall the engagement in this session was high throughout, with several insightful questions relating the results to illness noted. In particular the participants who had received a diagnosis of a personality disorder expressed curiosity surrounding their results and how the assessment would be influenced by their illness. This session combined content from two sessions in the original BYBS program, although the content was all covered. From a facilitation perspective the topics would be better explored separately over two sessions at a slower pace. By the end of the session, the participants were able to verbalize an understanding of their top two intelligences and identify their colour of personality when asked.

The youth importance score for this session was the third lowest overall, and yet in the focus group the youth referenced their acquired knowledge from the session on several occasions. The practitioner feedback score was almost ten percent higher than the participant

feedback score, with qualitative responses indicating success with these topics at other agencies. Based on the field notes and post-program focus group findings, a future consideration for this session would be to eliminate colours of personality scale and focus on exploring the multiple intelligences.

Table 6.5 - Session 4 social validation scores

Session 4 Social Validation Scores			
	Importance	Skills	Usability
Mean	4.11	3.38	4.50
Minimum	2.00	1.00	3.00
Maximum	5.00	5.00	5.00
Number of Respondents: 6			

Six social validation scales were collected at the end of session four. With a mean score of 4.11 the participants felt strongly towards the overall value of the topic. The range was 3.00, suggesting some variability in the feedback, with none of the participants identifying topical irrelevance. With regards to their sense of improvement in the skills related to the topic, the participants indicated a feedback mean score of 3.38. There was a maximum range of 4.00 with regards to skills, which suggests there was at least one participant who felt that the session did not provide them with improved skills. With regards to their confidence that the skills and concepts are usable in their lives outside of the program, the participants also indicated a feedback score of 4.50. The range was 2.00 suggesting minimal variability in the feedback, with all participants indicating that the concepts were transferable outside of the program.

Session 5. The purpose of session five was for the participants to explore and understand the concept of free time activities (leisure) and the value they hold in recovery and living well. In addition, the participants were given the opportunity to connect personal strengths to preferred leisure activities.

In the recap of the previous session the participants were able to recall multiple intelligences and colours of personality with minimal prompting. The original plan for session five was to focus solely on expressing strengths through leisure activities. In particular leisure was discussed in the context of coping and adding balance to one's life. Prior to discussing leisure, the participants were given the opportunity to complete a modified signature strengths exercise that was intended to further support their strengths discovery. The assessment tool for this activity was modified based on the facilitator's clinical insights. The changes to this activity allowed the participants the opportunity to assess their own qualities based on descriptions, rather than the values they attached to particular words. Once the assessment was complete, the participants were given the responses for the second portion of the activity. Page two of the activity was a primary reference for the qualitative portion of the participant profiles. Figures 6.5 and 6.6 provide an illustration of the changes made.

In the second half of this session the participants connected their strengths to activities using a worksheet and were able to complete this task with minimal assistance. By the end of the session the participants had completed a list of possible leisure interests and were able to verbalize the value of leisure and expression of strengths when prompted. There was only a minor difference between the participant and practitioner feedback scores, supporting the effectiveness of this session overall.

Table 6.6 - Session 5 social validation scores

Session 5 Social Validation Scores			
	Importance	Skills	Usability
Mean	4.44	4.00	4.50
Minimum	2.00	1.00	3.00
Maximum	5.00	5.00	5.00
Number of Respondents: 6			

Six social validation scales were collected at the end of session five. With a mean score of 4.44 the participants felt strongly towards the overall value of the topic. There was a range of 3.00, suggesting some variability in the feedback, with none of the participants identifying topical irrelevance. With regards to their sense of improvement in the skills related to the topic, the participants indicated a feedback mean score of 4.0. There was a maximum range of 4.00 with regards to skills, which suggests there was at least one participant who felt that the session did not provide them with improved skills. With regards to their confidence that the skills and concepts are usable in their lives outside of the program, the participants also indicated a feedback score of 4.50. The range was 2.00 suggesting minimal variability in the feedback, with all participants indicating the concepts were transferable outside of the program.

Figure 6.7 - Original assessment tool

Signature Strengths, Self-Rating Scale
(Adapted by Jonathan Haidt, from M.E.P. Seligman, 2002: Authentic Happiness)

Everyone has a characteristic set of strengths and virtues, that is, things that they are "good" or "strong" on. Research in Positive Psychology suggests that there are (at least) 24 strengths and virtues that are recognized in most cultures.

Please read the descriptions of the 24 strengths and virtues below. As you read them, write a "+" in the margin next to the ones that you think describe you well. Write a "-" in the margin next to the ones that you think do not describe you well. Leave the rest unmarked. Then look through the ones with a "+" next to them and try to rank order your top 5. That is, place a "1" in the left-hand column for the one that you think best describes you, then a "2" in the next best one, etc. Finally, look through the ones with a "-" in the margin and try to rank the five that are LEAST true or applicable to you. That is, put a "24" next to the one that is least like you, then a "23", etc., out to 20. These might be considered your "weaknesses." But bear in mind that everyone has strengths AND weaknesses, and being honest about both will help you plan out a life that takes maximum advantages of your strengths.

Strength	Description
1.Curiosity Rank_____	You are curious about the world and you strongly desire experience of it. You are flexible about matters that don't fit your preconceptions. Curious people do not simply tolerate ambiguity but they like it and are intrigued by it. You seek out novelty, and you are rarely bored.
2.Love of learning Rank_____	You love learning new things, whether you are in a class or on your own. You always loved school, reading, museums - anywhere and everywhere there is an opportunity to learn. There are domains of knowledge in which you are the expert, and others value your expertise. You love learning about these domains, even in the absence of any external incentives to do so.
3.Judgment Rank_____	You think things through and examine them from all sides. You do not jump to conclusions, and you rely only on solid evidence to make your decisions. You are able to change your mind. You are very good at sifting information objectively and rationally, in the service of the good for yourself and others. You do NOT just think in ways that favor and confirm what you already believe.
4.Ingenuity Rank_____	When you are faced with something you want, you are outstanding at finding novel yet appropriate behavior to reach that goal. You are rarely content with doing something the conventional way. This strength is also called "practical intelligence" or more bluntly common sense or street smarts.
5.Emotional intelligence Rank_____	You are aware of the motives and feelings of others, and of yourself, and you can respond skillfully. You notice differences among others, especially with respect to their moods, temperaments, motivations, and intentions, and then you act upon these distinctions. You also have finely tuned access to your own feelings and the ability to use that knowledge to understand and guide your behavior.
6.Perspective Rank_____	You have a way of looking at the world that makes sense to others and yourself. Others seek you out to draw on your experience, and you are often able to help them solve problems and gain perspective. You have a good sense of what is really important in life.
7.Valor Rank_____	You do not shrink from threat, challenge, pain, or difficulty. Valor is more than bravery during physical threat. It refers as well to intellectual or emotional stances that are unpopular, difficult, or dangerous. The brave person is able to uncouple the emotional and behavioral components of fear, resisting the urge to flee and facing the fearful situation. Fearlessness, boldness, and rashness are not valor; it is facing danger, despite fear, that marks valor.
8.Persever-ance Rank_____	You finish what you start. You take on difficult projects and finish them, usually with good cheer and minimal complaint. You do what you say will do and sometimes more, never less. Perseverance does not mean dogged or obsessive pursuit of unattainable goals. Rather you remain flexible, realistic, and not perfectionistic.
9.Integrity Rank_____	You are an honest person, not only always speaking the truth but also living your life in a genuine and authentic way. You are down to earth and without pretense. You representing your intentions and commitments to others and to yourself in sincere fashion, whether by word or deed.
10.Kindness Rank_____	You are kind and generous to others, and you are never too busy to do a favor. You enjoy doing good deeds for others, even if you do not know them well. Your actions are very often guided by other people's best interests, even when these override your own immediate wishes and needs.
11.Loving Rank_____	You value close and intimate relations with others. You have deep and sustained feelings for others, who feel the same way about you. This strength is more than the Western notion of romance; it is about very deep ties to several or many people.
12.Citizenship Rank_____	You excel as a member of a group. You are a loyal and dedicated teammate, You always do your share, and you work hard for the success of the group. You value the group goals and purposes even when they differ from your own. You respect those who are rightfully in positions of authority, like teachers or coaches, and you identify with the group.
13.Fairness Rank_____	You do not let your personal feelings bias your decisions about other people. You give everyone a chance. You guided in your day-to-day actions by larger principles of morality. You take the welfare of others, even those you do not know personally, as seriously as your own, and you can easily set aside personal prejudices.
14.Leadership Rank_____	You do a good job organizing activities and seeing to it that they happen. You are a humane and effective leader, attending to getting the group's work at the same time as maintaining good relations among group members. You are additionally humane when you handle intergroup relations "with malice toward none and charity toward all."
15.Self- control Rank_____	You can easily hold your desires, needs, and impulses in check when it is appropriate. It is not enough to know what is correct; you must also be able to put this knowledge into action. When something bad happens, you can regulate your own emotions. You can repair and neutralize your negative feelings, and generate positive emotions on your own.
16.Prudence Rank_____	You are a careful person. You do not say or do things you might later regret. You wait until all the votes are in before embarking on a course of action. You are far-sighted and deliberative. You are good at resisting impulses about short term goals for the sake of longer term success.
17.Humility	You do not seek the spotlight, preferring to let your accomplishments speak for themselves. You do not regard yourself as special, and others recognize and value your modesty. You are unpretentious. You see your own aspirations, victories and defeats as pretty unimportant in the larger scheme of things.
18.Apprecia-tion Rank_____	You stop and smell the roses. You appreciate beauty, excellence, and skill in all domains: nature, the arts, science, and the wide range of abilities that other people possess. You often see or hear things cause you to feel profound feelings of awe and wonder.
19.Gratitude Rank_____	You are aware of the good things that happen to you, and you never take them for granted. You always take the time to express your thanks. Gratitude is an appreciation of someone else's excellence in moral character. We are grateful when people do well by us, but we can also be more generally grateful for good acts and good people. Gratitude can also be directed toward impersonal and nonhuman sources--God, nature, life – but it cannot be directed toward the self.
20.Hope Rank_____	You expect the best in the future, and you plan and work in order to achieve it. Hope, optimism, and future-mindedness are a family of strengths that represent a positive stance toward the future. Expecting that good events will occur, feeling that these will ensue if you try hard, and planning for the future sustain good cheer in the here-and-now and galvanize a goal-directed life.
21.Spiritual-ity Rank_____	You have strong and coherent beliefs about the higher purpose and meaning of the universe. You know where you fit in the larger scheme. Your beliefs shape your actions and are a source of comfort to you. You have an articulated philosophy of life, religious or secular, that locates your being in the larger universe. Life has meaning for you by virtue of attachment to something larger than yourself.
22.Forgive-ness Rank_____	You forgive those who have done you wrong. You always give people a second chance. Your guiding principle is mercy and not revenge. Forgiveness represents a set of prosocial changes that occur within an individual who has been offended or hurt by someone else. When people forgive, their motivations and actions regarding the transgressor become more positive (e.g., benevolent, kind, generous) and less negative (e.g., vengeful, avoidant).
23.Humor Rank_____	You like to laugh and bring smiles to other people. You can easily see the light side of life. You are playful and funny.
24.Zest Rank_____	You are a spirited person. You throw yourself body and soul into the activities you undertake. You wake up in the morning looking forward to the day. The passion that you bring to activities is infectious.

A much longer and more accurate version of this test can be taken at:
www.authentichappiness.org

For more information about strengths, happiness, virtue, and flourishing, see
www.happinesshypothesis.com

Figure 6.8 Revised Assessment Tool

Be Your Best Self Program – Youth
Session 5

	Description	Mostly Like Me	Sometimes Like Me	Not Often Like Me
1	I like to think of new and better ways of doing things			
2	I am always asking questions and love to discover new things			
3	I look at all sides of an issue to come up with the right answer			
4	I love to learn new things			
5	I am considered wise because I evaluate things from different perspectives			
6	I speak up for what is right, even if others do not agree with me			
7	I finish what I start, even if it because difficult			
8	I speak the truth and I take responsibility for my feelings and behaviours			
9	I live life as an adventure filled with excitement and energy			
10	I value the close relationships I have with others			
11	I enjoy helping others, even if I do not know them well			
12	I pay attention to the motives and feelings of others			
13	I always do my share and I work hard for the success of my group			
14	I treat all people in a fair and just manner			
15	I am good at providing leadership and direction when I am with a group of people			
16	I am willing to forgive someone who has done something wrong			
17	I am humble and let my actions speak more than my words			
18	I am careful about what I do and strive not to do things I might regret later			
19	I pay attention and am always in control of what I do and say			
20	I appreciate the beautiful and wonderful things in life			
21	I pay attention to the good things that happen to me and express my thanks			
22	I believe that good things are coming to me now			
23	I like to laugh, smile and see the good in all situations			

Please note: This exercise was adapted from the Character Strengths Inventory

Be Your Best Self Program – Youth
Session 5

WORDS THAT DECRIBE ME…

Most Often	**Sometimes**

Please note: This exercise was adapted from the Character Strengths Inventory

Session 6. The purpose of session six was for participants to begin to describe their best self, through highlighting the strengths and capacities previously discussed and to support the development of a "strengths based alternative story". Session six began with a recap of session five, prompting participants to recall the content from the previous session. The participants were able to articulate the benefits of free time activities with minimal prompting but struggled to articulate a personal plan for how they might use free time activities within their own lives. Session six focused on creating strengths based alternative stories. This session had a scaffolded worksheet that prompted the participants to explore this shift and the participants were engaged with the content. The worksheet was completed as a group, with each question being discussed and the participants responding privately on the page. The participants responded well to the guided approach, and all participants were able to successfully complete the activity. Best possible life part two was completed in partners, with each participant responding to the other. This collaboration allowed for personal connection between the participants, also insight as to how others saw their strengths. In the debrief the participants articulated that it remains easier to articulate the strengths of others than it does for oneself. By the end of the session, the participants were able to verbalize an understanding of the role of alternative stories in living well, when asked.

There was a marked difference between practitioner and participant feedback with regards to value. Practitioner value was high, while participant feedback was lower. Based on the feedback received in the debrief (as indicated in field notes), the participants felt a high degree of challenge with this session. Although all of the participants were noted as engaged and successfully completed the activity, it is possible that the lower feedback score is rooted in resistance to workload, rather than content.

Table 6.9 - Session 6 social validation scores

Session 6 Social Validation Scores			
	Importance	Skills	Usability
Mean	3.60	3.40	3.00
Minimum	1.00	1.00	1.00
Maximum	5.00	5.00	4.00
Number of Respondents: 5			

Five social validation scales were collected at the end of session six. With a mean score of 3.60 the participants felt less confident about the overall value of the topic. The range was 4.00, suggesting that there was at least one participant who felt that the session did not hold much topical importance, however, based on the mean score, the majority of the participants did.

With regards to their sense of improvement in the skills related to the topic, the participants indicated a feedback mean score of 3.4. There was a maximum range of 4.00 with regards to skills, supporting that at least one participant who felt that the session did not provide them with improved skills.

With regards to their confidence that the skills and concepts are usable in their lives outside of the program, the participants also indicated a feedback score of 3.00. This was the first session for which no participants indicated a "strongly agree" response to the transferability of the skills outside of the program. The range was 4.00 with a minimum score of 1.0 and maximum of 4.0.

Session 7. The purpose of session seven was to give participants the opportunity to understand the role of growth as a result of challenge. This session connected back to acceptance of circumstance discussed in previous sessions and focused on the development of hope for the possibility that something good can result from challenge. Session seven began with a debrief of the previous session, during which the participants expressed satisfaction with their accomplishments in the previous session. During the debrief the participants expressed that the

activity was a lot of work but reading their responses after the fact was gratifying. Within the recap discussion the participants identified challenges with futuristic thinking suggesting envisioning a life past where they were at felt somewhat inaccessible, as they have no frame of reference for what it might be like to achieve the much-wanted independence they described. This feedback is likely to inform changes to the session six activity, as previous consideration had not been given to the idea that envisioning an independent life is more accessible to the adult population than it is for adolescents.

Session seven focused on post traumatic growth, making lemonade out of lemons. There were several humbling moments throughout this session, beginning with our review of the handout during which the participants expressed a lack of familiarity with Christopher Reeves, who's story was central to the discussion of post traumatic growth. Figure 6.10 is a copy of the handout used in this discussion, with the quotation that challenged participants circled in red.

Figure 6.10 – Session seven handout

Making Lemonade out of Lemons
(Also known as Post-Traumatic Growth)

A meaningful life is not possible without a certain amount of suffering and an understanding of that suffering.

Acceptance of suffering + Recognition of choices and future possibilities = **Strength & Resilience**

Post-Traumatic Growth (PTG)

- Positive psychological change experienced as a result of the struggle with highly challenging life circumstances.
- PTG reflects that something has been gained following the trauma or adversity, rather than that something was lost but recovered or that nothing was lost despite the trauma.

"Acceptance of your condition is an essential first step in rehab. I began to face my new life. Gradually I realized that I had to learn to think of myself the way that I used to think about a new hobby or a new sport car. I had to be as disciplined about my body as I had been about learning to fly a plane, or sail a boat, or ride a horse. I had to understand exactly where I was now, and how I would be for the foreseeable future. How could I master my situation? Who would I become?"
(Christopher Reeves)

What does Post-Traumatic Growth Look Like?

1. **Greater Appreciation of Life:** Increased appreciation of the "smaller things" in life and a changed sense of what is important.
   Ex. Spending more time on relationships, appreciating each day and its small pleasures, taking life easier, and spending less time on unimportant things.
2. **Closer Relationships with Others:** PTG often involves increased ability to self-disclose, express emotions, and convey compassion to others.
3. **A Greater Sense of Personal Strength:** Increased awareness of possessing strengths related to surviving and living well.
   "If I survived this, I can survive anything"
4. **Recognition of New Possibilities for Life:** PTG involves acceptance that things have changed and that there are new possibilities for life. This also involves shifting goals from ones that may now be unattainable to new and more satisfying goals. It may also involve recognizing the possibility inherent in challenge.
5. **Growth in Wisdom and Perspective:** PTG often contributes to clarity about the meaning of life, an increased connection to spirituality, and wisdom.

Some clarifications

Most of us, when we face very difficult losses or great suffering, will have a variety of highly distressing psychological reactions. ***Just because individuals experience growth does not mean that they will not suffer.*** Distress is typical when we face traumatic events.

We most definitely are not implying that traumatic events are good – they are not. But for many of us, life crises are inevitable and we are not given the choice between suffering and growth on the one hand, and no suffering and no change, on the other.

The participants initially challenged the idea that there was a silver lining to their illness. They were resistant to the idea that good can come from trauma or struggle. The discussion for this session occupied more time than initially anticipated with many "ah-ha" moments noted by the observer as a result. The worksheet provided a space for the participants to list challenges as a result of their illness, which they completed quickly. The participants were then required to list the positives they had learned as a result of each challenge. The first two challenges for each participant were completed as a group, and the subsequent four they completed independently. The participants were all able to successfully complete the worksheet. By the end of the session, the participants were able to verbalize an understanding of post-traumatic growth with minimal prompting.

There was a marked difference between practitioner and participant feedback with regards to value for session seven, with this session receiving the lowest participant evaluation score overall. Feedback on this value score was received during the post-program focus group, the participants again demonstrated a clear understanding of PTG suggesting the application of this concept in the face of immediate challenge felt inaccessible. This feedback is likely to change session seven as well, as it is possible that the concept of PTG requires more futuristic insight than the adolescent population is able to provide.

Table 6.11 - Session 7 social validation scores.

Session 7 Social Validation Scores			
	Importance	Skills	Usability
Mean	3.83	4.00	3.75
Minimum	2.00	3.00	2.00
Maximum	5.00	5.00	5.00
Number of Respondents: 4			

Four social validation scales were collected at the end of session seven. With a mean score of 3.83 the participants felt strongly towards the overall value of the topic. There was a

range of 3.00, suggesting some variability in the feedback, with none of the participants identifying topical irrelevance. With regards to their sense of improvement in the skills related to the topic, the participants indicated a feedback mean score of 4.0. There was a maximum range of 2.00 (3.0 minimum and 5.0 maximum) with regards to skills, which suggests the participants felt an overall sense of improvement. With regards to their confidence that the skills and concepts are usable in their lives outside of the program, the participants also indicated a feedback score of 3.75. The range was 3.00 suggesting minimal variability in the feedback, with all participants indicating the concepts were somewhat transferable outside of the program.

Session 8. The purpose of session eight is to review the process of the program and to connect the sessions together. This session provides participants with the opportunity to explore the overarching concepts of the program and summarize what they have learned. Upon arrival to the facility, the facilitator and research assistant were debriefed privately on an event that had happened within the house a few hours earlier. At approximately 3pm that day, one of the residents sent out a message to several other past and present residents of the facility via social media. The message indicated a plan for suicide and the recipients quickly responded by advising the staff on duty. The staff intervened immediately, to discover that the resident had already consumed medications and was shifting in and out of consciousness. Police and ambulance were called immediately and intervened on scene. The resident was taken to the local hospital, where they were stabilized.

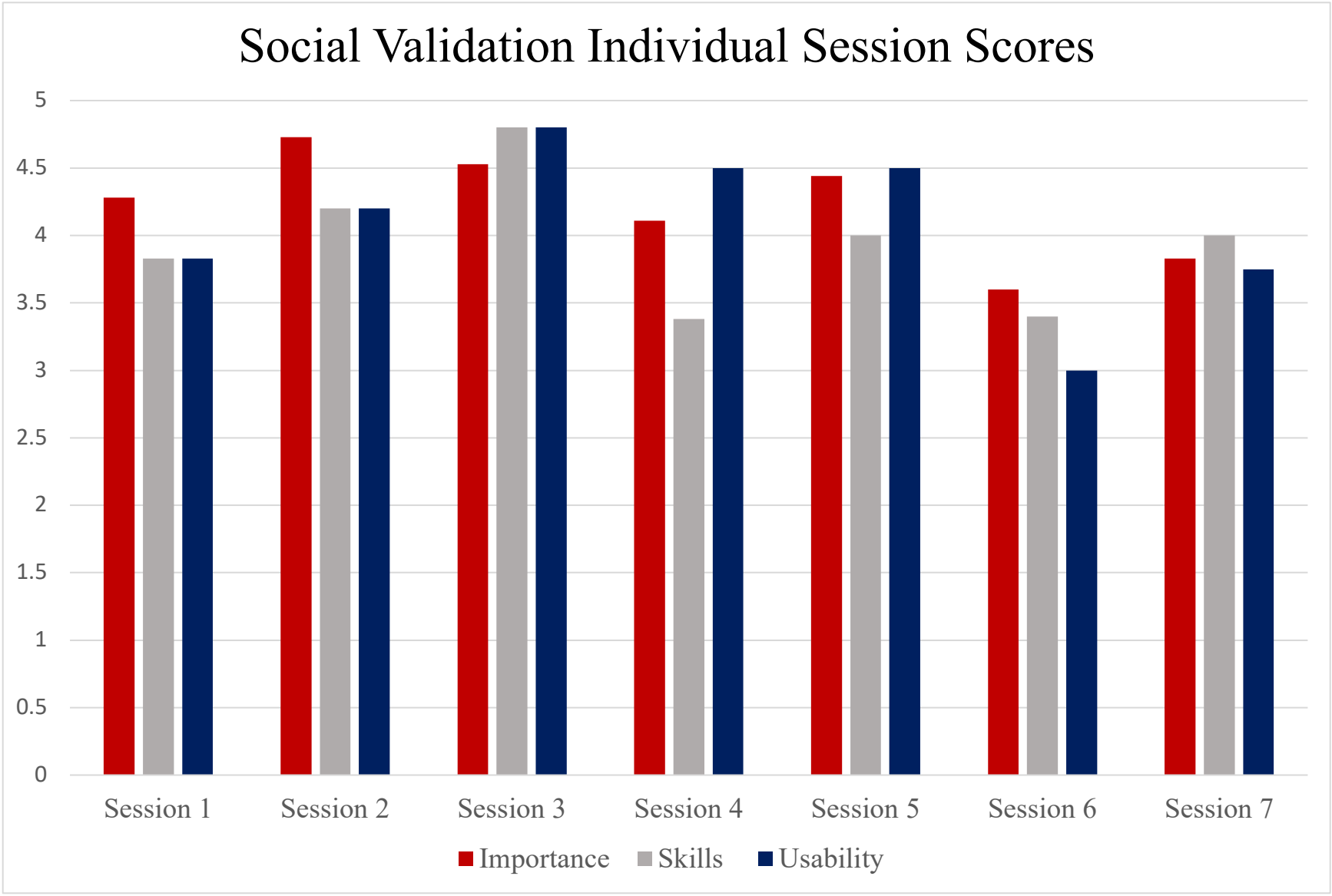
The BYBS-Y participants appeared quite distraught upon arrival to the facility but agreed to attend the program session as planned. Session eight began with a debrief of the impact the earlier event was having on each of the participants and provided them with an opportunity to share their own perspectives. The facilitator used reflective listening and validation strategies to

normalize the feelings expressed. As the discussion came to a natural close, the facilitator asked the group if they would like to participate in a reflective exercise to review the BYBS-Y program. The group agreed, with one participant stating, “I think it would be good to distract myself with an activity”. The participants were able to complete the session eight reflective exercise with relative ease and the discussion after the activity indicated a clear sense of growth with regards to the participants’ knowledge of their own personal strengths. By the end of the session the clients were able to verbalize three key concepts that they had learned in the BYBS-Y program.

As mentioned in chapter three, the research assistant for this project was an experienced facilitator of the original BYBS (adult) program. As such, the insights provided by the research assistant often contained reflection in comparison to the previous program. As was indicated in the fieldnotes, the adolescent population demonstrated ease with the final activity, which was in contrast to previous experiences facilitating the same activity within the adult population. Among the possible explanations for this difference could be the intensity of the youth program, immersing them deeper into a strengths-based environment with shorter intervals between sessions or greater responsiveness of the developing brain. In the post-program focus group the participants were quick to reflect on the “daisy” activity being easy to complete and felt that the tree would also have been interesting to repeat at the end as further demonstration of their growth. Within this discussion the participants expressed feeling competent with strengths-based language and knowing how to respond to the prompts given in reflective activities such as these. They expressed feeling a sense of accomplishment with the daisy activity, as it represented what they had learned and allowed the opportunity to reflect on how different they felt about

themselves as a result. Figure 6.12 provides a summary graph of the results of the BYBS-Y program scores, as discussed.

Figure 6.12 - Individual Session Scores

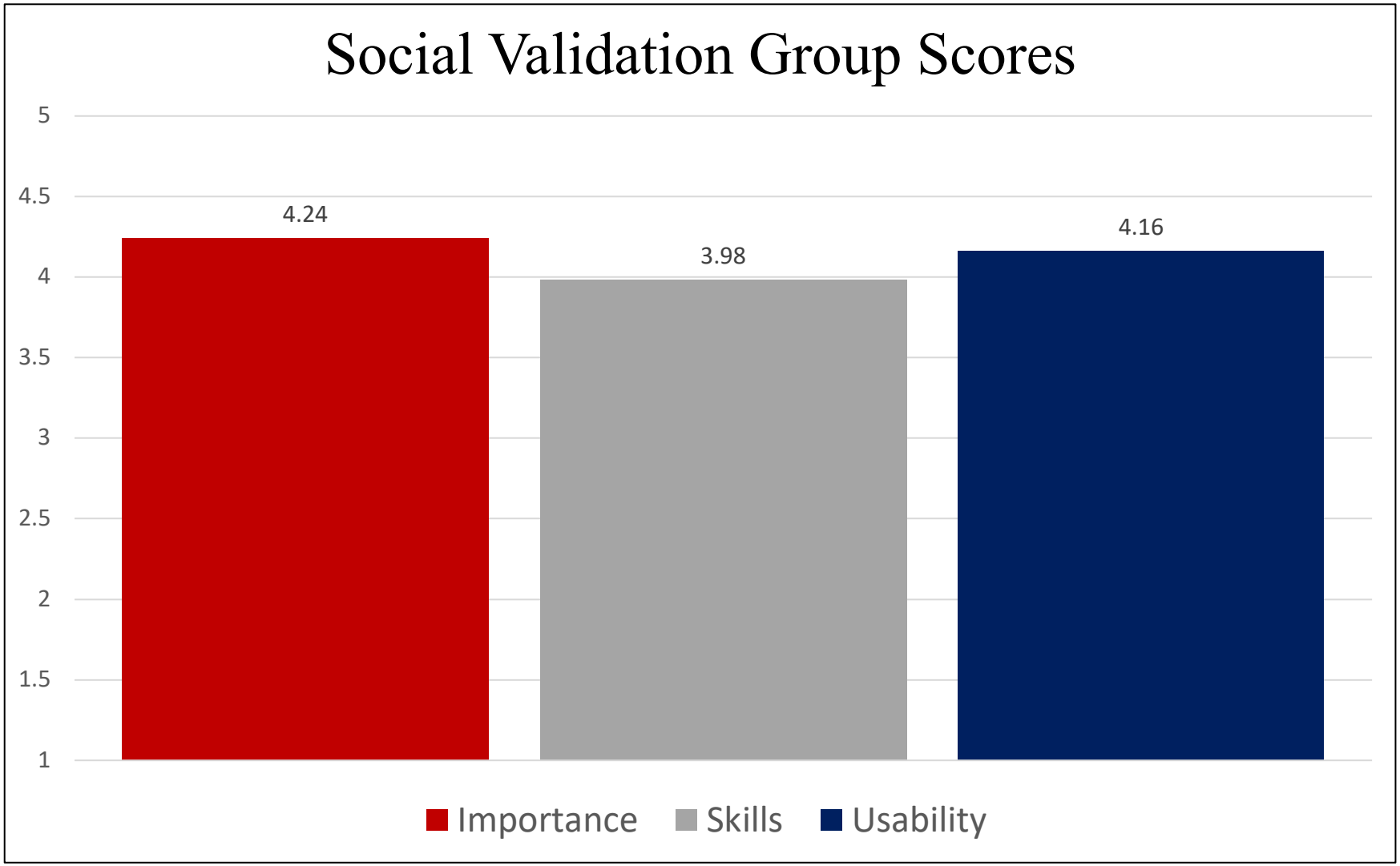


Social Validation Measures

The overall purpose of the BYBS-Y program is to provide opportunities for participants to begin to shift their sense of self from that of a person with many limitations to that of a person who has both limitations and strengths. Throughout the program the activities and discussions focus on the idea of re-writing one's personal narrative by incorporating increased awareness of strengths and increased ability to use and develop strengths through free time engagements.

A total of thirty-seven social validation scales were collected over the first seven sessions. Session eight was not included in the social validation measure as it was a wrap up reviewing the key topics from each week. With an overall mean score of 4.24 the participants felt strongly towards the overall value of the topics covered throughout the BYBS-Y program. With an overall mean score of 3.98 the participants indicated a sense of improvement in the skills related to the topic. Finally, with an overall mean score of 4.16, the participants indicated confidence that the skills and concepts within the BYBS-Y program are usable in their lives outside of the program. The range of the mean scores was 0.26 which supports some variability in the feedback across the program with the majority of responses suggesting value across the various topics, progress gained and likelihood of transferability. Figure 6.13 provides a summary graph of the social validation mean group scores.

Figure 6.13 - Overall Program Scores

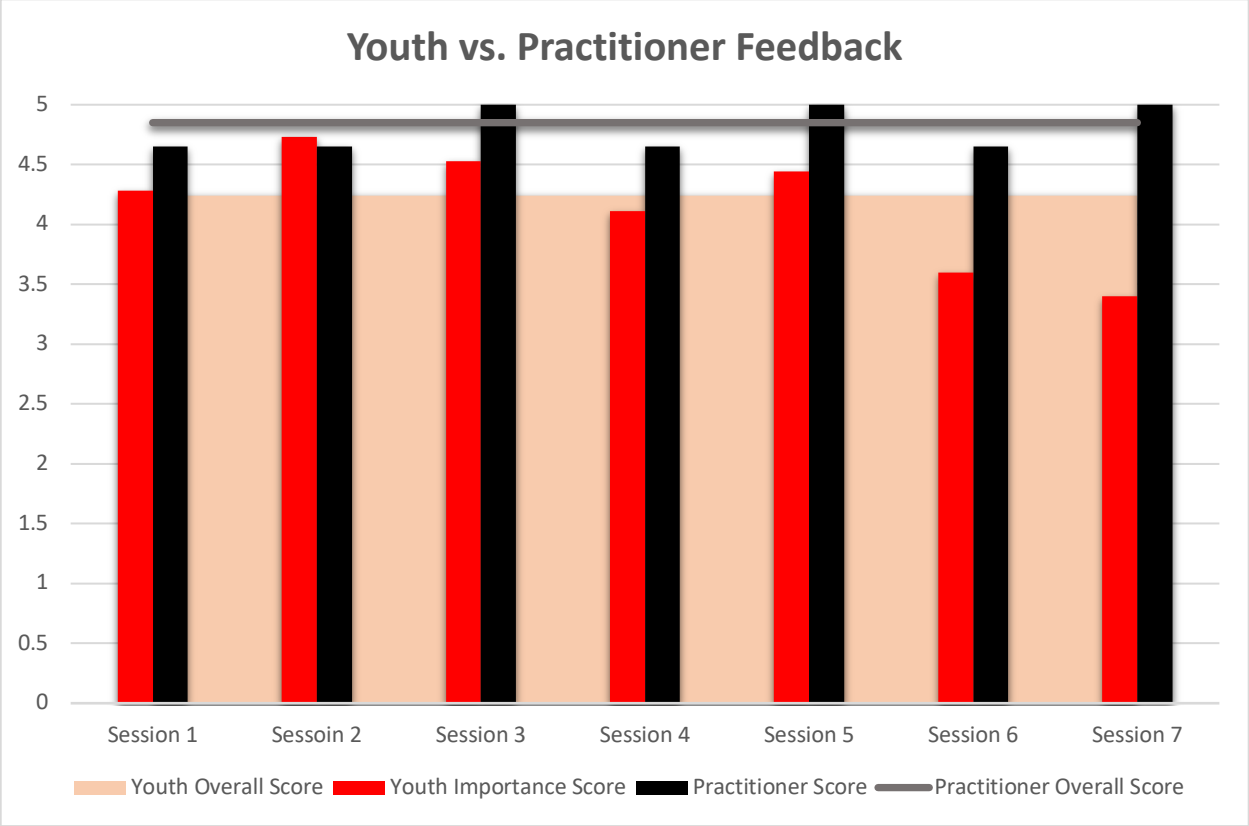


Youth vs. Practitioner Feedback

The purpose of phase two was to solicit feedback from practitioners to augment the clinical expertise of the primary investigator and ultimately to strengthen the design of the program before implementation. Phase two was the quickest to complete, while ultimately providing a clear indication that the focus of the program held value within the population. Having others with formal education in a particular area review a program and provide critical feedback gives the author food for thought and a point of reference for deeper reflection. The process of soliciting feedback from fellow practitioners informed a sense of confidence in the BYBS-Y program and could hold great value if practiced regularly in the TR profession.

Practitioner feedback supported a high level of approval for the individual sessions. As such, the results from phase two did not inform any changes to the program prior to the phase three program implementation. However, the feedback scores from phase two were later compared to the social validation scores from phase three in an effort to explore the gap that might exist between professional and client experiences. There was limited variance between the practitioner and youth feedback scores with regards to importance for the first five sessions, while sessions six and seven showed further divide. This discrepancy was explored in the post-program focus group with youth indicating that sessions which are future-oriented are less relatable to youth, as they do not have lived experience to support this type of thinking. This finding serves to illustrate a possible discrepancy that can occur between practitioner and client. Figure 6.14 provides a summary graph comparing the social validation session scores to the practitioner feedback session scores. This graph also includes the overall mean importance score from youth and the overall mean score from practitioners.

Figure 6.14 – Youth vs. Practioner Feedback Scores



Outcome Evaluation

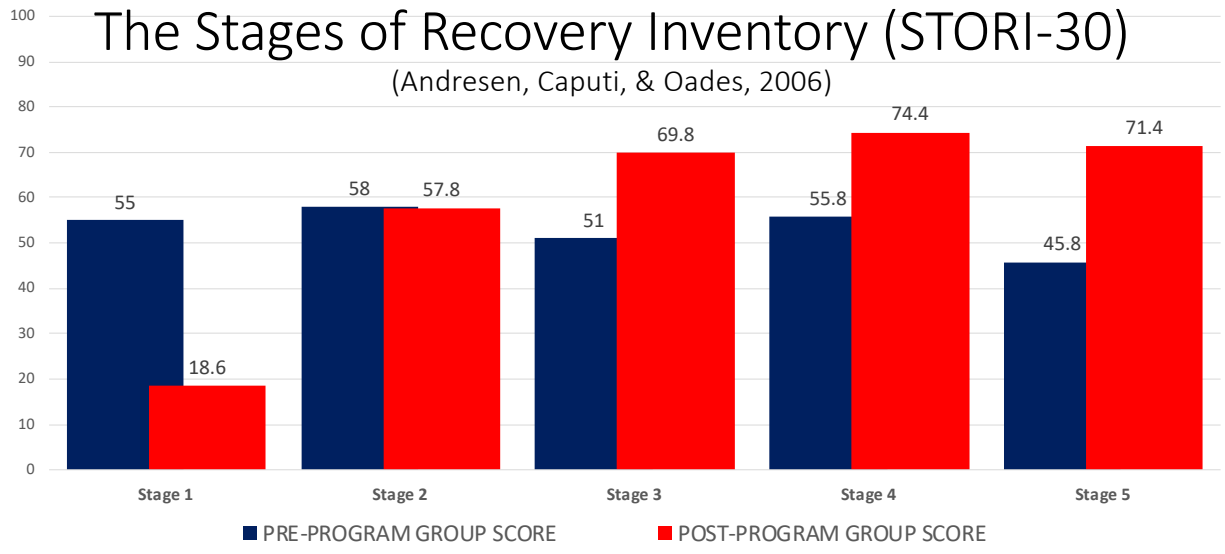
Pre and post assessment measures.

This project was a qualitative, interpretive, phenomenological study that incorporated the use of standardized assessment tools within the phase 3 pilot evaluation in an effort to generate personalized scores for discussion purposes within the sessions while exploring the usability of the assessment tools with regards to client understanding and applicability to the sessions. Each of the five assessments used generated a different base score, which would have made discussions less accessible to unfamiliar readers. Percentage scores were generated for clarity and accessibility in the dissemination of results. By converting each of the scores into a percentage value, a standardized reference point was created, and the discussion of results is thereby simplified. While no parametric analysis was conducted to determine statistical significance of the scores generated from the pre-and-post assessments, the scores discussed in this section serve to illustrate evidence that some positive change had taken place over the five weeks that the participants were participating in the BYBS-Y program.

Stages of Recovery Inventory. The Stages of Recovery Inventory (STORI-30) (Andresen, Caputi, & Oades, 2006) was used to evaluate recovery progression. The STORI-30 is a measure that targets psychological recovery and personal growth and assesses where individuals are in the process of recovery (identified as stage of recovery) from mental illness. The recovery stage is indicated by highest score across the five stages. The stages of recovery are: Stage 1 Moratorium; Stage 2 Awareness; Stage 3 Preparation; Stage 4 Rebuilding; Stage 5 Growth. As represented below there is a reduction in the stage one pre and post scores by 36.4%, a reduction in the stage two scores by 0.2%, an increase in the stage three scores by 18.8%, an increase in the stage four scores by 18.6% and an increase in the stage five score by 25.6%.While

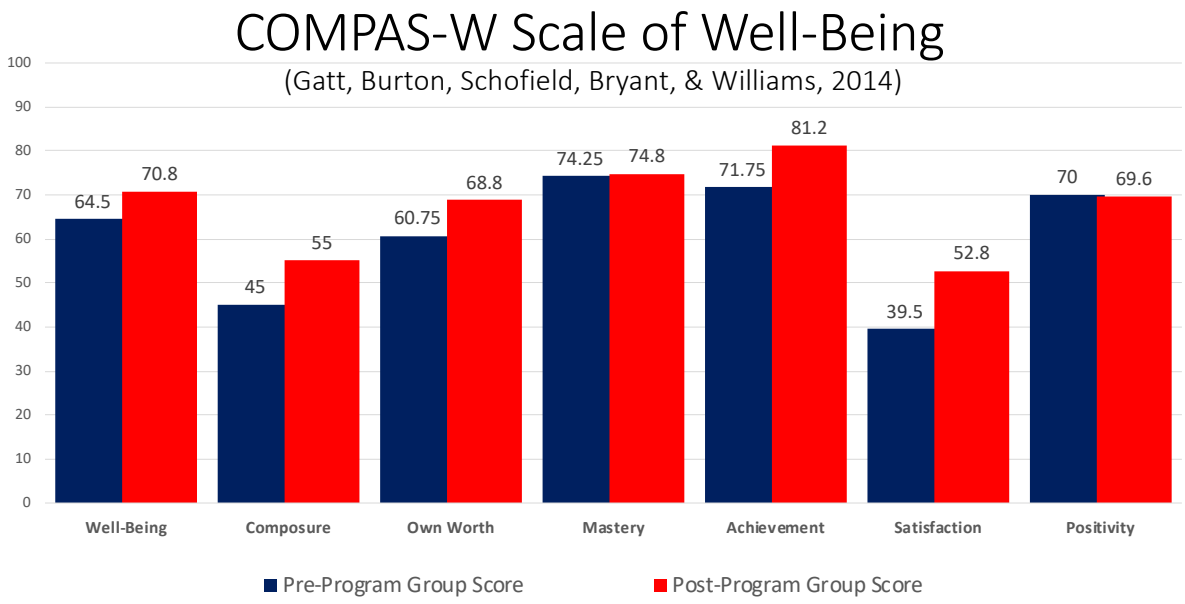
statistical significance has not been confirmed, these findings suggest an overall group progression through the stages of recovery. Figure 6.15 provides a summary graph of the stages of recovery inventory results.

Figure 6.15 - Summary of the Stages of Recovery Inventory Results



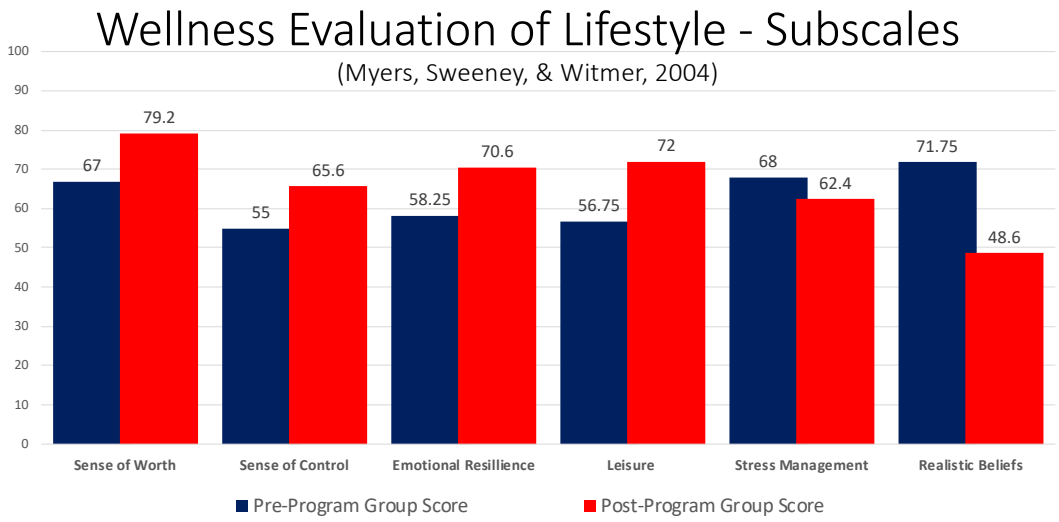
COMPAS-W Scale of Well-Being. The COMPAS-W Scale of Well-Being (Gatt, Burton, Schofield, Bryant, & Williams, 2014) was used to generate values for composure (competency and adaptability in stressful situations), own-worth, mastery, positivity, achievement, satisfaction and well-being. The scores of the COMPAS-W indicate that there is a positive change in well-being with the total score increasing 18.6%. The group composure score increased 10%; the group own worth score increased 8.05%; the group mastery score increased by 0.55%; the group achievement score increased 9.45%; and the group satisfaction score increased 13.3%. In contrast, the group positivity score decreased by 0.4%, which will be discussed in the chapter seven. Figure 6.16 provides a summary graph of the COMPAS-W scale of well-being results.

Figure 6.16 – Summary of the COMPAS-W Results



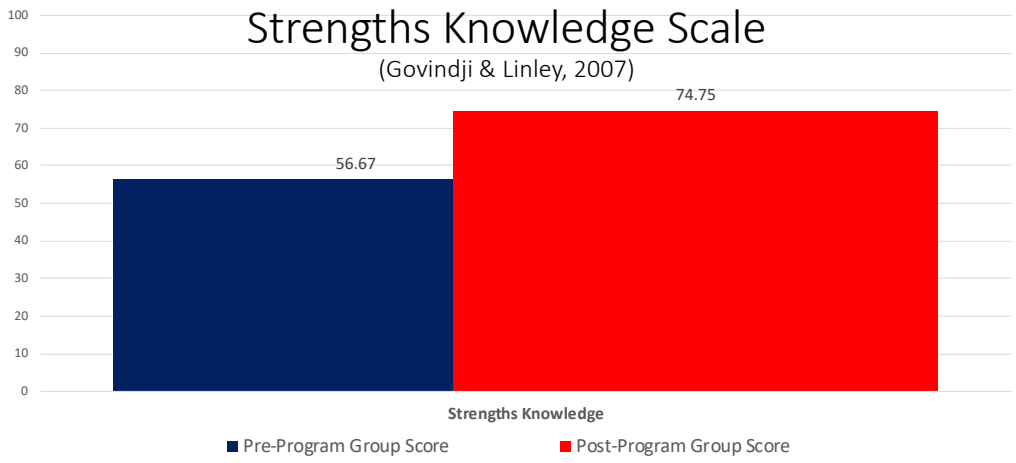
Wellness Evaluation of Lifestyle Subscales. The selected subscales of the Wellness Evaluation of Lifestyle (Myers, Sweeney, & Witmer, 2004) were used to generate values for sense of worth, sense of control, realistic beliefs, emotional resilience, stress management and leisure. The Wellness Evaluation Lifestyle Subscales support improvement in four of the six domains. The group sense of worth score increased by 12.2%; the sense of control score increased by 11.6%; the emotional resilience score increased by 12.35%; and the leisure score increased by 15.25%. In contrast, the score for stress management decreased by 5.6% and the score for the realistic beliefs decreased by 23.15%; further discussion of this will be explored in chapter seven. Figure 6.17 provides a summary graph of the Wellness Evaluation of Lifestyle results.

Figure 6.17 – Summary of the Wellness Evaluation of Lifestyle Results



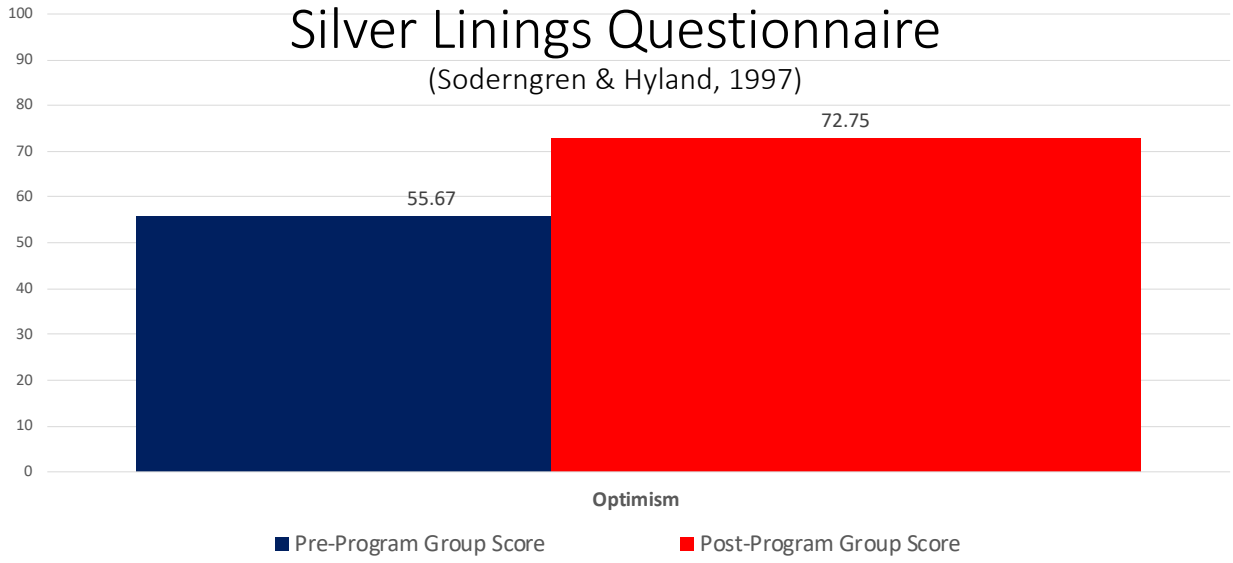
Strengths Knowledge Scale. The Strengths Knowledge Scale (SKS) (Govindji & Linley, 2007) was used to generate the strengths knowledge values. The SKS was completed at the start of session two and then repeated at the end of session seven. The SKS measures the degree to which an individual is aware of their own strengths. The results from the strengths knowledge scale group score support an increase of 18.08% overall. Figure 6.18 provides a summary graph of the SKS results.

Figure 6.18 – Summary of the Strengths Knowledge Scale Results



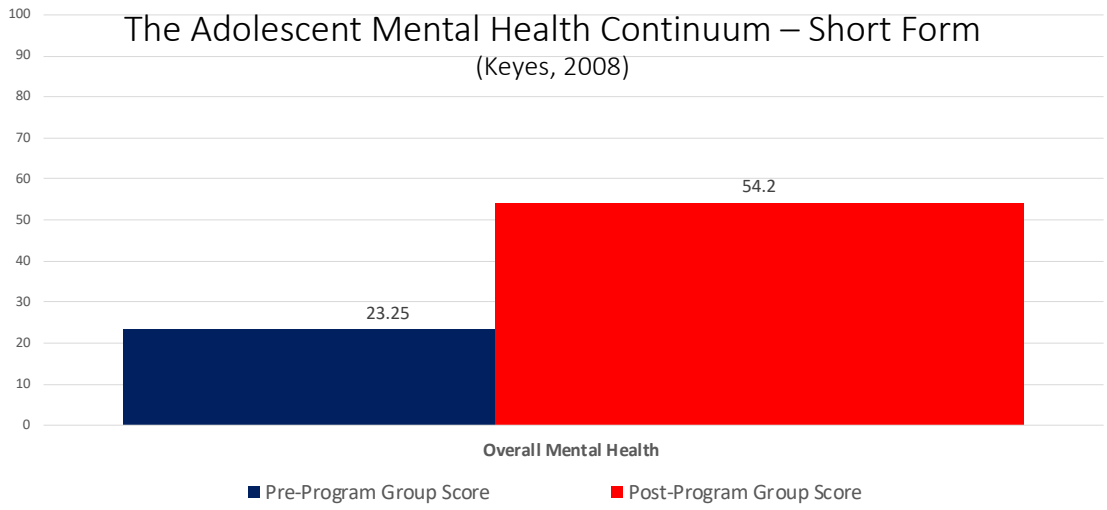
Silver Linings Questionnaire. The Silver Linings Questionnaire (Soderngren & Hyland, 1997) was used to generate the value score for optimism. The Silver Linings Questionnaire was administered at the start of the second session and the repeated at the end of session seven. The results from the Silver Linings Questionnaire group score support an increase of 17.08% overall. Figure 6.19 provides a summary graph of the Silver Linings Questionnaire results.

Figure 6.19 – Summary of the Silver Linings Questionnaire Results



Adolescent Mental Health Continuum – Short Form. The Adolescent Mental Health Continuum – Short Form (A-MHC-SF) (Keyes, 2008) was used to generate the overall mental health value score. The results from the Adolescent Mental Health Continuum group score show**ed** an increase of 30.95% overall. Figure 6.20 provides a summary of the A-MHC-SF results.

Figure 6.20 – Summary of the Adolescent Mental Health Continuum Results



Post-Program Focus Group

Following the completion of the BYBS-Y program, four of the participants attended a post-program focus group. The focus group took place on Thursday, April 18th, 2019 from 6:00-7:30pm which aligned naturally with the program schedule. In this focus group, each participant was provided with a participant profile of their engagement in the BYBS-Y program and asked to respond to both the program as a whole and to their individual profiles. The focus group was audio recorded and coded thematically. The findings from the focus group support two central themes (1) program content and (2) supportive environment outcomes. The remainder of this outlines the findings from the phase 3 post-program focus group, this section includes purposeful quotations from each of the participants in an effort to represent the group voice.

Program Content

The discussion began with the topics that stood out the most to the participants. When asked, they were quick to generate responses that highlighted aspects from sessions one, five, and eight. Session one focused on buy-in and illustrating the concept of narrative for participants. This was done through an activity that used music and two of the participants highlighted the impact of such

> *The session at the beginning with the music stood out the most for me. I remember listening to the first song and feeling like I wanted to cry and the hearing the second one and by the end I had literally gotten up and started dancing Not realizing until we talked that it was the exact same lyrics. That was a big moment for me, that was when I realized something about you was different than anyone I'd ever gotten help from and I felt excited to be a part of your program.*

Echoing their peer, another participant stated "*Ya, I agree. The music one changed my perspective on things, I realized that the tune that you sing your story to makes it feel different*"

Session five focused on strengths identification. This was done through a signature strengths exercise that was added to the program as a result of the insight gained in the preceding sessions. The participants leading up to this session appeared to be resistant to strengths-based language and struggled with identifying characteristics within themselves but were quite comfortable doing so for others. This change proved to be impactful for the clients and was also highlighted in their discussion.

> *The one activity where you took the words away and we just responded to the sentences and then you showed us the outcomes was really awesome. I don't think I would have learned as much about myself without that activity because you were right about the words being barriers and how we kept judging ourselves base on our understanding of the words instead of learning more about what it means to be that word.*

Session eight focused on recapping the focus of the program and provided clients with the opportunity to use the skills gained over the preceding seven sessions in an activity that generated a flower to illustrate a more balanced version of themselves. Two of the focus group participants highlighted this session as being impactful for them.

> *The end sessions stood out to me the most because the worksheets got easier to complete. I don't think it is because the content was easier, I think it is because I actually understood more about myself and had gained the ability to talk about my strengths.*

Further evidence of the impact of the skills gained through the program was articulated by another participant who ascribed additional meaning to the eight session.

The last session was pretty memorable for me, I was having a really bad day with everything that had happened in the house before you arrived but forcing myself to participate in the session with you actually made me feel a hell of a lot better and I've never been able to turn around a bad day like that before.

When asked what surprised the participants the most about the BYBS-Y program they unanimously identified knowledge of strengths as being both a surprising and impactful take-away for them. "*When I first started this program, I would have never thought I would be strong but now I feel like I am because I know it takes strength to still be alive and I learned that in this program.*" In agreement, "*Ya, before this program I never would have described myself as brave, but I know now that I am and that feels pretty good*." In addition, the participants expressed being able to shift away from self-harm and suicide and envision more positive outcomes for their future.

Before I did this program, I didn't think I would have a future, I had accepted the fact that I would probably kill myself before I would ever have a chance to do anything. Now I kinda feel like I have something. I get that I will always have challenges because of my illness but I also think I have things to look forward to.

When I came to treatment, I only pictured myself with dying in a painful and tragic way. Your programs [BYBS] made a big difference for me, I actually feel happy with where I am and see my journey to getting this point differently. I don't want to die anymore.

When asked what they had learned about the connection between narrative and free time activities the participants were able to make the connection among identity, narrative and leisure

without further prompting. As one participant explained, "*I've learned that your actions define how you feel and if I make choices to do things that focus on my strengths it actually makes me feel better.*" Another participant went on to describe how the program has helped her to shift how she sees herself. "*I still have really bad self-esteem, but it's not as bad as it used to be and when I look at my profile on paper and I see the words around my name I can see my strengths and I actually believe them."*

In an effort to further explore the knowledge they had retained from the BYBS-Y program, the participants were asked to describe themselves using three words, three were able to do so without hesitation stating "*Funny, happy and smart*"; "*happy, kind and caring*"; "*creative, curious and brave*". Further evidence of their familiarity with strengths-based language was when the fourth participant appeared to struggle with response and the other participants chimed in quickly on her behalf stating she was: "*kind, charming*"; "*funny, brave, sassy, strong*"; "*beautiful, likeable, huggable, great, a good friend*" and lastly "*kinda like a Cadbury mini egg: hard shell on the outside but very sweet and delicious on the inside*".

The participants were asked to provide some expert feedback on changes for the program before future implementation. This feedback was minimal but informative. First, the participants unanimously agreed that session two: the tree of life needed to either be at the end of the program or eliminated. Upon further discussion, one participant stated, "*I hated the tree"* and another echoed *"ya, definitely take away the tree!*". The only other feedback received was a request for additional content. One of the participants suggested that greater focus on the use of positive language would be a helpful skill to practice. "*I would suggest adding more opportunity for positive self-talk because it's really hard to practice. When my illness takes over, I feel like I'm unlovable, so getting better are positive self-talk and using tools in those moments would be*

really helpful." As another added, "*and maybe more information about diagnosis so we can better understand what our label means too*."

The participants were given the opportunity to review individual participant profiles that were created for them and asked to discuss what they saw. Figure 6.21 provides an example of a participant profile created from a complete data set. Some of the participants took note of the words on the page before discussing the graphed results.

> *I notice the words more than the chart and I noticed right away that you added self-harm and [diagnosis] to it, I like that, it makes me feel like you're aren't trying to fix me, you see it's part of who I am, but there are so many other words on the page too and know it's not all of me*.

Another stated:

> *I'm surprised by how comfortable I feel looking at the words around my name, when we first started this program it was really hard to come up with one thing nice to say, and now not only to I see the words and feel okay about them, I kinda believe them because I understand them better*." Another echoing, "*ya, this makes me feel like I'm worthy of love*.

Figure 6.21 – Sample Participant Profile

The participants also noted the graphed improvements on the page. "*When I look at it, I'm most surprised to see how much my mental health scores went up, that feels really good! I didn't realize how low I was when the group first started and seeing the change makes me want to keep trying because I now know it's possible to live better than I was before*". In response, another said,

> *Ya, seeing how much my sense of worth score increased was the most surprising to me, I mean I know I feel better about myself after talking about my strengths this much, but I didn't realize that it had made that much of a difference for me*.

While a third said, "*This chart tells me that I do have a sense of worth and I do have a sense of control and I can get through the tough times*."

Lastly, the participants were asked if they experienced any "ah-ha" moments in the BYBS-Y program, to which each had a meaningful response that indeed connected back to the

purpose and design of the program. As the first participant shared, "*in the leisure activities session, I sort of realized there are A LOT of things that I can do and that I know make me happy, like, why am I not doing them?*". While the next stated,

> *Yes! For me, positive atmosphere of the program and knowing that we weren't going to be talking about our problems the whole time was good. Knowing we were going to look at our challenges and turn them into something better was what I liked the most. Going to group therapy gets tiring because it's like a bitch fest where everyone is just talking about why they are here and not doing anything with it, but in this group we admit our struggles but we spend way more time on the part of us that isn't broken and that feel different than anything I've experienced in treatment before – in a good way!*

The next participant spoke about the power of externalizing one's illness and related it back to self-harm as his ah-ha moment, "*I now use spite to win against my urges to self-harm as stupid as it sounds, I tell myself: My depression wants me to lose, so I'm going to win*." Speaking to both the impact of the program and the facilitator, the final participant noted:

> *In this program I felt noticed, I don't know if it was the program or just you, but it felt good to know that I had strengths and that an adult that I admired could see them. I used to fake who I was, now I think I can be more of myself and I feel proud of my journey. Last week I wore short sleeves and my kilt to school every day which is something I haven't done for a few years. I'm okay with people seeing my scars because they're part of my journey and I think if people can't see the pain behind each one, then they're not worth my time. My scars used to be what I wanted to hide from and now they are evidence of how brave and strong I actually am. Every day I wake up and I don't have a new cut, that is a battle I have won with myself. I know I will always have urges and the*

days I do wake up with a new cut I've won a different battle, because I actually woke up that day.

Supportive Facilitation

The previous section provides some anecdotal evidence that the program itself is effective with youth. However, as highlighted in phase one, youth hold particular needs for environmental support in order to establish therapeutic relationships that are conducive for learning. These findings informed the purposeful interactions with youth that took place throughout the BYBS-Y implementation. Interestingly, the therapeutic alliance that was created between the facilitator and the participants was brought into the discussion several times throughout the focus group, dominating more than twenty of the forty-six-minute interview. The feedback received from the focus group will be outlined briefly in this chapter while the overall experience from the facilitator's perspective will be explored in chapter seven.

Phase one findings supported that honesty and transparency were of particular importance for youth experiencing mental health challenges as they contribute to the establishment of trust which is foundational to a therapeutic relationship. Further evidence of such is how one participant focused on the facilitator when asked about the impactful moments of the program early on in the focus group.

One of the most impactful things about this program for me was being able to see the human aspect of you instead of just the professional doctor person you are. You sat on the floor with us, you took your shoes off, you didn't eat and drink where we weren't allowed to, and you let us ask you questions about your life and your family without trying to mysterious and pretend like you didn't have a life outside of this place.

Reliability, consistency and mutual respect were also noted as requirements for establishing an environment that supports change. Youth want to know that those helping them are going to show up and be present to have conversations that might take additional time or be separate from the primary visit.

> *The time before group when I pulled you aside to tell you how well I was doing and thank you for saving my life and allowing me to believe in the future was something I will remember forever. The way you interacted with me all throughout the program made me feel like I mattered and like you actually cared*.

Further evidence of the environment created through these interactions was voiced by participants as they expressed the impact of the unconditional positive regard.

> *It is really obvious to me that you've put your heart and soul into this program and into making a difference for us and it's pretty incredible to meet someone that isn't just doing it for the sake of their job, or because they have to for school. It felt like we mattered to you, and that made it easier to learn*.

As the interview was winding down, the participants were given an opportunity to share any final thoughts they had. The following are the final two responses in the focus group, which illustrate well the overall impact the program appears to have had on the participants. These comments speak to both the quality of the content and the facilitation:

> *I just want to say my only hope is that the next program we do here is half as good and run by half as great as a person as you are. This isn't my first time in treatment and this program is different than anything I've ever experienced – in a good way*.

I want to say thank you. The skills I've learned through this program tell me I'm worth something, and at the beginning of your visits I would have said I'm not too sure. Part of what I'm grateful for is the opportunity to learn these skills, but more so the opportunity to experience a therapist who saw me for me and not my diagnosis. You were patient on the days we were disruptive, and you allowed us to be teenagers, but at the same time, you made us want to keep coming and learning because it felt good to do this with you.

Chapter 7 – Discussion

This project served to explore the value of a therapeutic recreation (TR) program that supports positive identity formation, providing opportunities for youth to explore their sense of self and begin to envision a life of purpose and satisfaction. Using a three-phase process, this research designed, implemented and evaluated an intervention that translated practices associated with living well and supported opportunities to explore the development of the capacities deemed necessary to create a life of meaning while managing a mental illness. This research was guided by a central question: *How might a therapeutic recreation intervention designed to [broadly] support the development of a positive personal narrative impact adolescents' perceptions of living well with mental illness?*

The BYBS-Y program was a central component of all three phases of this research project. In phase one, the lived experiences of youth were explored and subsequently informed the revisions made to the original BYBS program which was intended for use in adult outpatient psychiatry. In phase two, feedback on the preliminary design of the program was sought from TR practitioners who had experience working in the Adolescent mental health population. Finally, in phase three the BYBS-Y program was implemented at a residential treatment facility for youth living with mental illness and evaluated for effectiveness using standardized pre-and-post-program measures and a focus group.

Therapeutic recreation (TR) is an allied health profession that focuses on choices and engagement in one's discretionary time. The purpose of the field is to enhance individual's ability to engage in meaningful, freely chosen leisure activities that increase outcomes such as positivity, autonomy, optimism and social engagement, to name a few. Effective TR service supports the psychological, emotional and social development for those who are challenged by,

in this case, mental illness (Carruthers & Hood, 2007; Hood & Carruthers, 2007; 2013; 2016a; 2016b). The results of the BYBS-Y program are valuable in the context of therapeutic recreation practice as the participants in phase one had clearly articulated experiencing elements of struggle in daily living. By focusing on the development of programs that facilitate opportunities for clients to harness the skills and capacities necessary to engage in leisure, they are equipped with the ability to cope with future challenges and increase levels of resiliency.

TR is particularly useful for supporting individuals in the pursuit of leisure engagements that are personally satisfying and compliment one's strengths and capacities. The positive outcomes supported by the implementation of the BYBS-Y program validate the need for therapeutic recreation services for children and adolescents who are experiencing mental health challenges. As voiced in the post-program focus group, the BYBS-Y program was unlike any other services the participants had received previously and held value for them in their journey towards recovery. In this regard, what set the BYBS-Y program apart from other treatment programs was the primary focus on strengths within the therapeutic setting as this priority modeled positive self-regard for clients and supported the development of a therapeutic working relationship through which the participants then began to connect with their whole self (Carruthers & Hood, 2007; Davidson et al., 2006; Hood & Carruthers, 2007; 2013). Through the facilitation of the BYBS-Y program the participants had the opportunity to explore activities that were personally gratifying, and the findings supported evidence of a shift in their internal desire for change that led to descriptions of optimism for the future. This project affirms the value and necessity of TR services in the lives of those who are accessing child and adolescent mental health services moving forward and highlights a current gap in Niagara that should be explored further.

Chapter six outlined descriptive and qualitative evidence that the BYBS-Y program is effective in supporting positive change across several domains connected to adolescent development and recovery. Scores measured through standardized assessment tools were presented to illustrate areas of change. The data collected throughout phase three provide some preliminary suggestion that the BYBS-Y program does broadly support the development of a positive identity that in turn impacts participant perceptions of living well with mental illness. The BYBS-Y program had a particularly strong focus on strengths, and it was clear that this focus positively influenced the effectiveness of the program and therefore should be explored further. In the post-program focus group, the participants expressed a clear connection to the facilitation of the program, leading the principal student investigator to the conclusion that there is a bi-directional relationship between content and process that must be recognized if a program is to be successfully implemented. The following pages will explore the results of the program further in order to unpack the outcomes and to present future considerations.

This chapter has been divided into four sections in order to best serve the reader. Section one will explore the program related findings in connection to recovery. Section two will highlight the value of employing a strengths-based approach. Section three will discuss the facilitation related findings. And, section four will conclude the chapter with personal reflection of the experience and a brief outline the potential future directions for the BYBS-Y program.

Section One: Program Related Findings

The BYBS-Y program is an intervention designed to support youth in their process of recovery. Leamy and colleagues (2011) conducted a systematic review (meta-analysis) of 97 papers across 13 countries to better understand personal recovery and to develop a conceptual framework for supporting such. In congruence with literature outlined in chapter two, the

characteristics of recovery identified included confirmation that it is highly individualized, non-linear, an active process rather than an outcome, a life-changing experience and not synonymous with cure (Leamy et al., 2011). Further, Leamy et al. (2011) described the process of recovery using five core categories: **C**onnectedness, **H**ope and optimism, **I**dentity, **M**eaning and purpose, and **E**mpowerment, referred to as the "CHIME" framework.

In this section, the BYBS-Y pre-and-post program measures will be connected to the CHIME categories, with leisure and well-being measure scores from the pre- and post-program assessments extending the work of Leamy and Colleagues (2011) further to become CHIME+. There are several figures embedded throughout this discussion to provide visual representations of each category.

Connectedness

Connectedness in recovery focuses on the importance of positive relationships in the context of living well, recognizing that humans have an innate desire to feel loved, accepted and understood in their current condition (Leamy et al., 2011). Slade and Wallace (2017) suggest there is limited evidence for interventions which improve connectedness as a direct outcome but, rather, that connection is best supported through vocational/educational pursuits and meaningful activities (Crowther et al., 2001). Connection was not a central focus of the BYBS-Y program, however in the post program focus group, there was some evidence that the group-based delivery bridged opportunities for connectedness amongst the participants through shared experiences, which often served to normalize struggles and celebrate success. As one participant explained: *"I liked how we did the activities together and could hear each other's experiences, it made me feel less alone when I was having a shitty day."* In this regard, it is possible that connectedness is a central component to all effective recovery-oriented treatment, as central to this process is the

recognition of the individual rather than the illness, and the development of therapeutic helping relationships – both of which could result in the experience of love, acceptance and understanding.

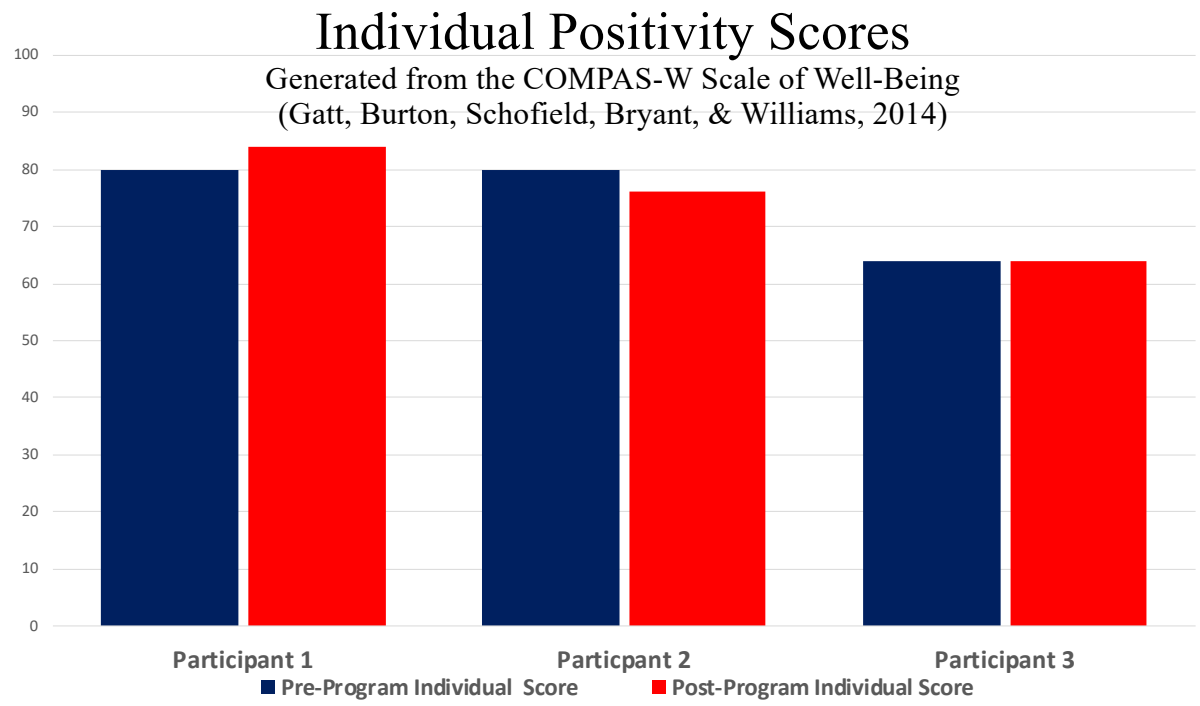
Hope and Optimism

Hope and optimism are rooted in the possibility that life could be better than it currently is (Leamy et al., 2011). Hope and optimism from the CHIME framework were linked to the following subscale scores from the pre-and-post program measures: positivity, emotional resilience, and optimism. In chapter two, hope and optimism were discussed in relation to positive emotion. Identifying increased levels of positive emotion can lead to a greater sense of openness towards challenges that facilitates opportunities for change. In chapter four, the phase one focus group participants articulated their need for believing that their future wouldn't be defined by their current state of struggle. There is literature to support positive outcomes for hope-based interventions, often approached through coping skills development, goal setting exercises and peer support, to name a few (Schrank et al., 2012). The BYBS-Y program supported the development of hope through the exploration of self, using a strengths-based dialogue.

There were several pre- and post-program measures used that generated scores that appear to be connected to hope and optimism. The Positivity subscale of the COMPAS-W Scale of Well-Being (Gatt et al., 2014) generated a value for positive emotion, which decreased by 0.4% in the overall group average. Rocke, Li and Smith (2009) suggest that there is a high degree of individuality associated with the experience of positive and negative emotion, and daily fluctuation with such is normal across the lifespan, while the degree of variability decreases with age. Figure 7.1 summarizes the individual positivity scores for the three complete datasets,

while statistical analysis has not been conducted, there does appear to be a lack of change between the pre and post scores. There is limited explanation regarding the positivity scores as they were not explored directly in the post-program focus group nor is there evidence to qualify statistical significance. However, it is certainly possible that the incomplete suicide of one the participants, as discussed in chapter six, impacted the positivity scores as it occurred just hours prior to the post-program assessments. Perhaps this unexpected experience should have been explored within the focus group to better understand the impact. It is also possible that clients experience positivity differently as a result of treatment and there may be value in exploring how this could be better understood. If the latter is the case, and we know positive emotion is central to the development of resiliency but is thwarted in the face of active treatment, what is the impact overall on those receiving services and how might this be addressed to better serve the population as a whole?

Figure 7.1 Individual Positivity Scores

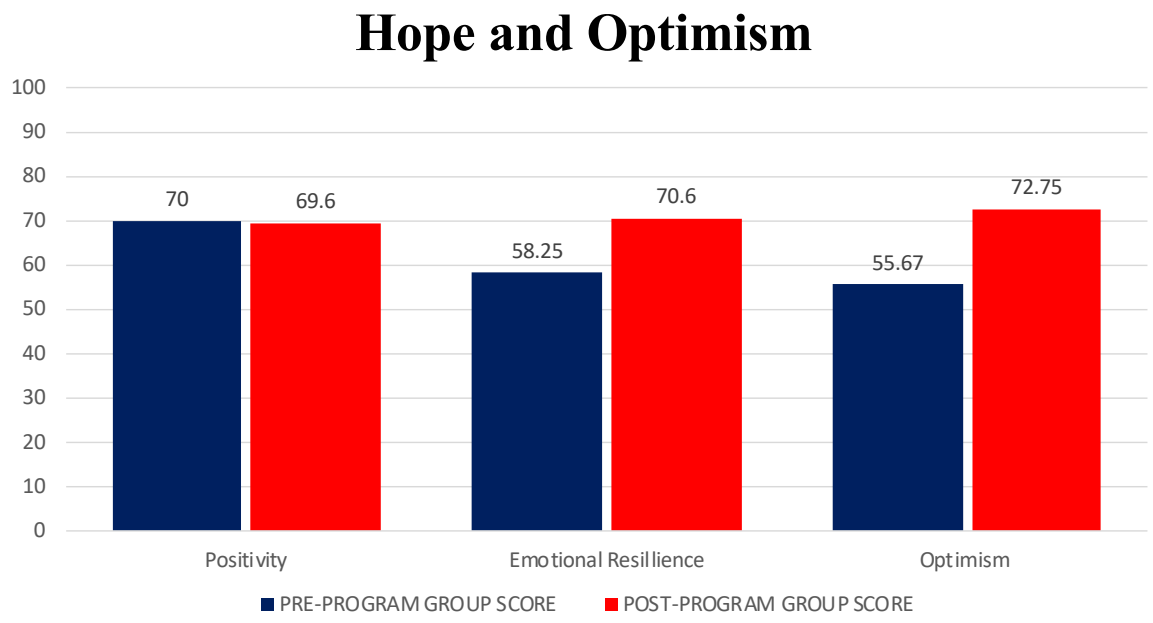


One of the subscales of the Wellness Evaluation of Lifestyle (Myers et al., 2004) was used to generate values for emotional resilience, which showed an increase of 12.35% overall, while statistical analysis was not conducted to qualify significance, the scores do support change. Rajan-Rankin (2014) explored the connection between identity and resiliency in university aged 'adults' suggesting "self-hood and emotional resilience are intrinsically linked" (p.2429). Within the context of the BYBS-Y it possible that the increase in emotional resilience score was connected to the exploration of self and increased awareness of one's strengths and capacities as evidenced by several of the post-test measures. This finding was particularly encouraging given that an inability to tolerate distress was an identified concern following the phase one focus group. Although emotional resilience is indeed linked to identity, within the CHIME+ framework, one's ability to overcome emotional distress would seem integral to the generation of hope while valanced by optimism.

Skinner and Wellborn (1994) identified optimism as the primary factor that reduces emotion and behavioral problems, as stressors are then perceived as less threatening to basic needs. The Silver Linings Questionnaire (Soderngren & Hyland, 1997) was used to generate the value score for post-traumatic growth, which can be viewed as a form of optimism, results of which revealed an increase of 17.08% overall for the BYBS-Y participants, while again statistical analysis was not conducted to qualify significance, the scores do support change in a positive direction. In a meta-analysis, Malouff and Schutte (2017) concluded that optimism can be increased through purposeful interventions that provide opportunities for participants to envision better versions of themselves and explore tangible ways achieve such. The BYBS-Y program focuses significantly on the exploration of one's best self, as such effective facilitation of the sessions should, without question, yield a positive change in optimism score. Despite this

being an anticipated result, without further measure of the program in future group settings, it is difficult to substantiate this effect as a direct outcome of the program itself. Figure 7.2 provides a visual illustration of the pre- and post-program measure scores connected to hope and optimism as discussed.

Figure 7.2 Hope and Optimism Scores



Identity

Identity is rooted in the sense one holds of who they are, and what they have to offer those around them as a result (Leamy et al., 2011). Perhaps as a result of the complexity that surrounds the acquisition of such knowledge, there is a lack of published interventions that support the development and maintenance of a positive identity (Slade & Wallace, 2017). As discussed in chapter two, identity is influenced by external factors, and developed through independent experiences. Early adolescents begin to develop their identity by exploring the world outside of family with friendships becoming their primary focus. Peer groups maintain a

high level of influence over youth as their social skills continue to grow and it is through peer relationships that youth most often experience belonging and rejection (Steinberg, 2020).

Positive identity formation and reconstruction was identified as a primary goal for the BYBS-Y program, effects of which proved successful with increased values across all identity-related subscales. Identity from the CHIME framework was linked to the following subscale scores from the pre- and post-program measures: strengths-knowledge, own-worth, and sense of worth.

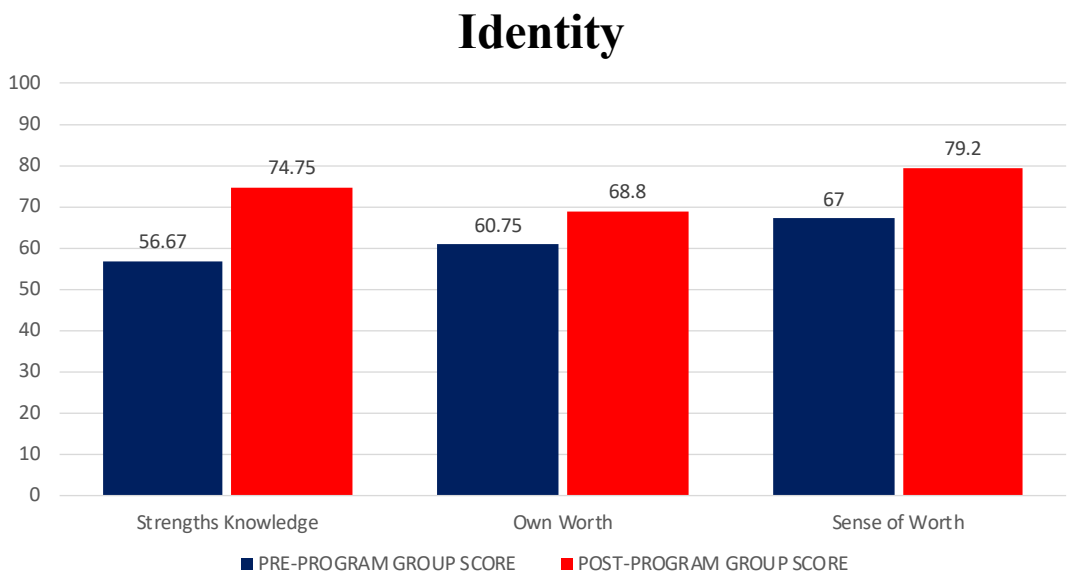
The Strengths Knowledge Scale (SKS) (Govindji & Linley, 2007) was used to measure the impact of the BYBS-Y program on awareness of personal strengths and scores revealed an increase of 18.08% overall, a gratifying but intended outcome of the program. While statistical analysis was not conducted to qualify significance of this score, the change in pre and post score do suggest change has occurred. The knowledge of personal strengths and capacities is particularly important in positive identity development as such knowledge serves to support individuals in the exploration of interests that serve their best self.

The Own Worth subscale of the COMPAS-W Scale of Well-Being (Gatt et al., 2014) was used to evaluate one's own worth with an increased score of 8.05% overall with the BYBS-Y participants. The Sense of Worth subscale of the Wellness Evaluation of Lifestyle (Myers et al., 2004) were used to generate values for sense of worth, revealing an overall increase of 12.2%. While statistical analysis was not conducted to qualify significance of either score, the increase does support a positive shift in the participant's self-reporting. The worth-based scores were intended to measure autonomy and self-esteem, both of which were identified in chapter two in connection to positive development in adolescents. Park (2004) agrees, suggesting that the identification and cultivation of character strengths is directly connected to positive youth

development, further iterating that such character education also teaches young people moral virtues such as respect, compassion, responsibility, self-control, and loyalty. Although measures of respect and compassion were not directly taken, there may be value in exploring this further in the context of the BYBS-Y program, as the participants actively described experiences of stigma and disregard from adults.

Bauminger et al. (2008) describe sense of self in connection with attachment, suggesting that there is a reciprocal relationship between one's attachment to a particular person or group and the development of their identity. Moreover, they suggest that individuals who do not have previous experience with attachment to parental figures face challenges with identity development in the adolescent life stage, as healthy attachment is the foundation to the development of one's sense of self. Though many of the participants in the BYBS-Y program were challenged by parental relationships, it is possible that the effective facilitation mediated the sense of connection and acceptance needed to begin exploring sense of self within the program. In fact, Brown and Lohr (1987) might agree, as they suggest that group therapy environments can buffer the alienation one feels in other contexts and through safe connection with facilitator and participants, self-esteem and self-worth can begin to develop. Finally, Danish, Taylor, and Faxio (2006) suggest that leisure and recreation is a primary avenue for development of one's identity in the adolescent life stage, as it provides context for intimacy, achievement and acceptance. In addition, they provide examples of sports-based life-skills programs that are in line with values of therapeutic recreation practice. Figure 7.3 on the following page provides a visual illustration of the scores related to identity discussed in this section.

Figure 7.3 Identity Scores



Meaning and Purpose

Meaning in life is a spiritual and highly individualized process that involves one's ability to synthesize experiences beyond the current moment and interpret such in the context of their own beliefs (Leamy et al., 2011). While purpose is connected to meaning, in the context of youth it is about the external actions taken to accomplish something that is in line with one's values. "The search for meaning and purpose is key to achieving the fortuitous ends envisioned by the positive psychology movement, such as authentic happiness, flow, and creativity" (Damon, Menon, & Cotton Bronk, 2004, p.120). A sense of meaning and purpose in everyday life is directly connected to increased levels of well-being (Carruthers & Hood; Hood & Carruthers, 2007). Meaning and purpose from the CHIME framework was linked to the following subscale scores from the pre- and post-program measures: satisfaction, composure, and realistic beliefs.

The Satisfaction subscale of the COMPAS-W Scale of Well-Being (Gatt et al., 2014) was used to evaluate a measure of meaning for the BYBS-Y program with the group satisfaction score increasing by 13.3% overall. While statistical analysis was not conducted to qualify

significance of this score, the increase does support evidence of some change nonetheless. Within the BYBS-Y program, the exploration of meaning and purpose is valanced by free time activities and underpinned by leisure values, suggesting that leisure provides space for individuals to experience the opportunities to express and explore character strengths. This in turn fosters a sense of achievement and has the potential to increase levels of satisfaction. As a result of the increased satisfactions score, one might also expect to see an increased achievement score, as one's knowledge of self increases, so too should their sense of accomplishment if for no other reason than as the mere product of committing to and completing the the BYBS-Y program itself.

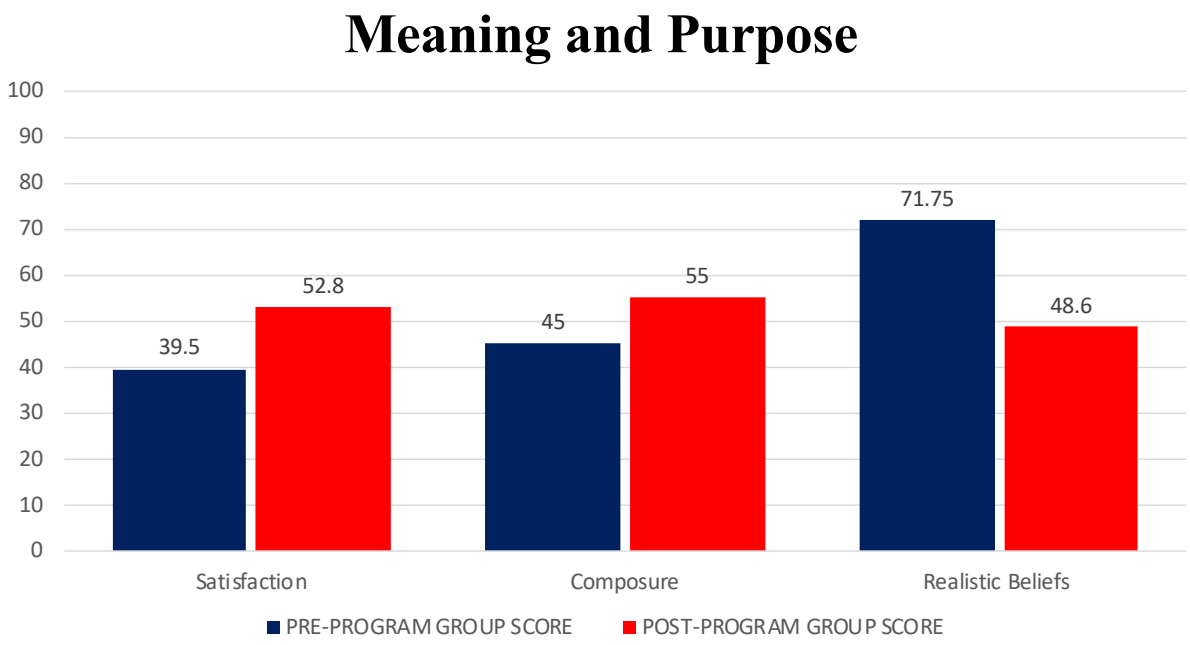
The Composure subscale of the COMPAS-W Scale of Well-Being (Gatt et al., 2014) was used to evaluate sense of composure, which is competency and adaptability in stressful situations. The calculated composure score represented a 10% increase overall following the completion of the BYBS-Y program. While statistical analysis was not conducted to qualify significance of this score, the increase does support evidence of some change, nonetheless. This increase is particularly interesting given the environmental conditions brought about by one participant's incomplete suicide on the date of collection. This leads me to question whether there is a relationship between composure and positivity, with the former being less fluctuant than the later.

The Realistic Beliefs subscale of the Wellness Evaluation of Lifestyle (Myers et al., 2004) were used to generate the last measure associated with meaning and purpose. The score for realistic beliefs showed the most significant decrease across all of the measures used, falling a total of 23.15%. While statistical analysis was not conducted to qualify significance of this score, the decrease does support evidence of some change. Myers and Sweeney (2004) suggest that

there may be an inverse relationship between realistic beliefs and stress management in the context of coping. As such, it is possible that the realistic beliefs score generated by the post-program assessment was influenced more by circumstance than the program itself. As described in chapter six, prior to the start of session eight (during which the post-program evaluations were collected), I was debriefed on the incomplete suicide of one the participants and the impact it was having on the other participants in the group. As a result, I question whether the realistic beliefs score is a reflection of the event or the program itself and, further, the affect it had on the participant's positivity scores. It is certainly possible that the program did not serve to effectively address this development and should be further explored. However, it is also worth questioning whether the participants had become emotionally grounded by the post-test which could have led them to the employment of active coping during this time which could then influence the realistic beliefs scores negatively.

Moreover, the challenges associated with futuristic thinking were discussed in chapter six and lead me to question whether there is a relationship between the realistic beliefs score and challenges associated with future orientation. What is clear is that this gap should be explored further and might help to inform how the future-based sessions could be modified and better support the development of realistic beliefs. Figure 7.4 provides a visual illustration of the scores related to meaning and purpose discussed in this section.

Figure 7.4 Meaning and Purpose Scores



Empowerment

Empowerment focuses on advancing directives surrounding personal responsibility and sense of control (Leamy et al., 2011). Empowerment in the CHIME framework was linked to the following subscale scores from the pre- and post-program measures: stress management, mastery, achievement, and sense of control.

The Stress Management subscale of the Wellness Evaluation of Lifestyle (Myers et al., 2004) was used to generate the first measure related to empowerment, revealing a decreased score of 5.6% following the BYBS-Y program. While statistical analysis was not conducted to qualify significance of this score, the decrease does support evidence of some change which is worthy of further exploration. Although it is certainly possible that the scores were influenced by the unsettling event that had happen only a few hours prior to the administration of the post-program evaluations it is equally possible that the intensity of the "work" required by the program was experienced by the participants as stressful in the moment. In fact, the sessions

require active engagement and thinking, which is in opposition to current literature on effective stress management techniques.

Stress management in the adolescent population is particularly important, as their brains can experience significant changes in both structure and function as a response. The hippocampus, medial prefrontal cortex and amygdala are implicated in stress reactivity and sustained or ongoing reaction in this regard increases risk for psychological disorders (Romeo & McEwen, 2006). Mindfulness-based stress reduction (MBSR) is regarded as the most widely accepted evidenced-based stress management program for youth, with consistent efficacy supporting a reduction in physiological and psychological symptoms of stress (Chiesa & Seretti, 2009; Kabat-Zinn, 2003). It is possible that rising levels of stress in children and youth could account for increased numbers of those seeking treatment for anxiety and depression and at younger ages than ever before. Matheny, Aycock, and McCarthy (1993) discuss several factors that influence stress in young people, including family (relationships), school (achievement), gender and geographical location (culture), further to which one might also add mass-media (virtual electronic submersion).

Literature supports evidence that several structures of the brain are compromised during this life stage which make youth particularly vulnerable to psychological instability (Romeo & McEwen, 2006). It is clear that further exploration is needed in order to better understand how stress management could be supported. Throughout the BYBS-Y program, the participants expressed experiences of stress across all domains and these challenges were often unpacked in the process of the activities. Given the level of challenge the BYBS-Y participants faced in their daily lives, it seems reasonable for their stress management scores to remain fluctuant during treatment. This also leads to questioning whether stress management measures are temporally

influenced and if so, should stress management be measured more than once throughout the program to create a curve rather than just an outcome score? Either way, perhaps an appropriate remediation for the sub-par stress management scores would be the integration of a mindfulness-based exercise at the start of each session in place of the interactive ice-breaker activities in an effort to better ground the participants before engagement.

The Mastery and Achievement subscales of the COMPAS-W Scale of Well-Being (Gatt et al., 2014) were the second and third measures used to examine empowerment for the BYBS-Y program, with the group mastery score calculating an very small increase of 0.55%, and the achievement scores showing an increase of 9.45% overall. While statistical analysis was not conducted to qualify significance of this score, the increase does provide some evidence of change. In chapter two it was suggested that leisure can provide opportunities for individuals to develop a sense of mastery which can be translated later into other contexts. In the BYBS-Y program, leisure interests were explored but opportunities for engagement in such activities were minimal, based on the nature of the residential treatment environment. Given this constraint, it would be interesting to evaluate changes in mastery measures following discharge, as this might afford greater insight into personal growth outside of the treatment environment ultimately providing an illustration of the sense of agency clients begin to assume within their own recovery. In contrast, there was a larger increase in the achievement score, which might suggest that clients experience a sense of accomplishment in the BYBS-Y program. As such, it is certainly possible that an increased achievement score in the immediate, could positively influence their experience of mastery in the future. This potential relationship between mastery and achievement lends further support to the need for longitudinal measures to better understand the short- and long-term impact of the BYBS-Y program overall.

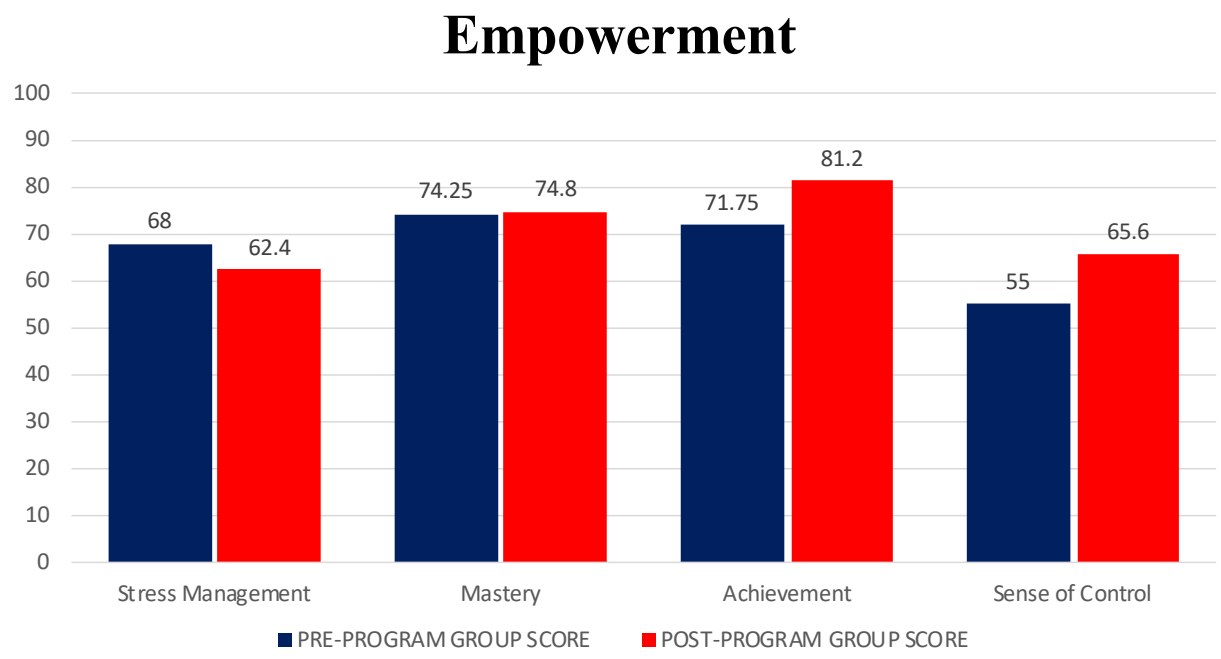
The Sense of Control subscale of the Wellness Evaluation of Lifestyle (Myers et al., 2004) was the final measure used to examine empowerment, and it showed an increase of 11.6% overall. While statistical analysis was not conducted to qualify significance of this score, the increase does provide some evidence of change. Chapter two discussed sense of control (autonomy) for the adolescent population, outlining developmental literature that illustrates the central connection it holds with development through to the early adult life stage (Steinberg, 2020). In this regard, it seems realistic to suggest that any effective treatment with youth should result in increased scores for autonomy, as there is an important relationship held between the developmental tasks of adolescents and the process of recovery. This also raises the question surrounding the relationship between strengths and sense of control: when youth are aware of their strengths and have opportunities to focus on such, is the combined result increased emotional resilience? Moreover, does this translate into hope and optimism for the future as a result of one's ability to buffer the challenges associated with ongoing mental health issues?

Central to empowerment is autonomy which involves the development and expression of independence and is central in adolescent development (Steinberg, 2017; 2020). Accordingly, decreasing emotional dependence on parental figures, independent functionality and the establishment of one's own personal values and morals mark the establishment of autonomy (Steinberg, 2017; 2020). Autonomy is underpinned by mastery, achievement and sense of control, measures of which increased by the end of the BYBS-Y program.

The notion of autonomy was particularly valuable in the context of facilitation, as literature suggests that adolescents are a self-governing body through which they often reject and are misunderstood by outsiders such as parents, siblings, teachers and other authority figures. In the presence of secure guidance, youth can begin to explore planning and goal achievement, but

in the absence of such, autonomous pursuits and futuristic thinking are challenged (Padilla-Walker et al., 2011). A considerable question could then be whether longer term facilitation with this group of participants would have changed their ability to employ future-based thinking, making the challenging activities discussed in chapter six more accessible. More generally, can effective helping professionals bridge the gap between unstable home lives and positive youth development and if so, is this only really accomplished in residential settings where environmental stability becomes central to treatment? Figure 7.5 provides a visual illustration of the scores related to empowerment discussed in this section.

Figure 7.5 Empowerment Scores



Leisure

Chapter two presented literature that supported leisure as a space that supports connection to a life that is socially, emotionally and physically healthy while creating facilitating opportunities for growth and development that allow the expression of one's best self. This

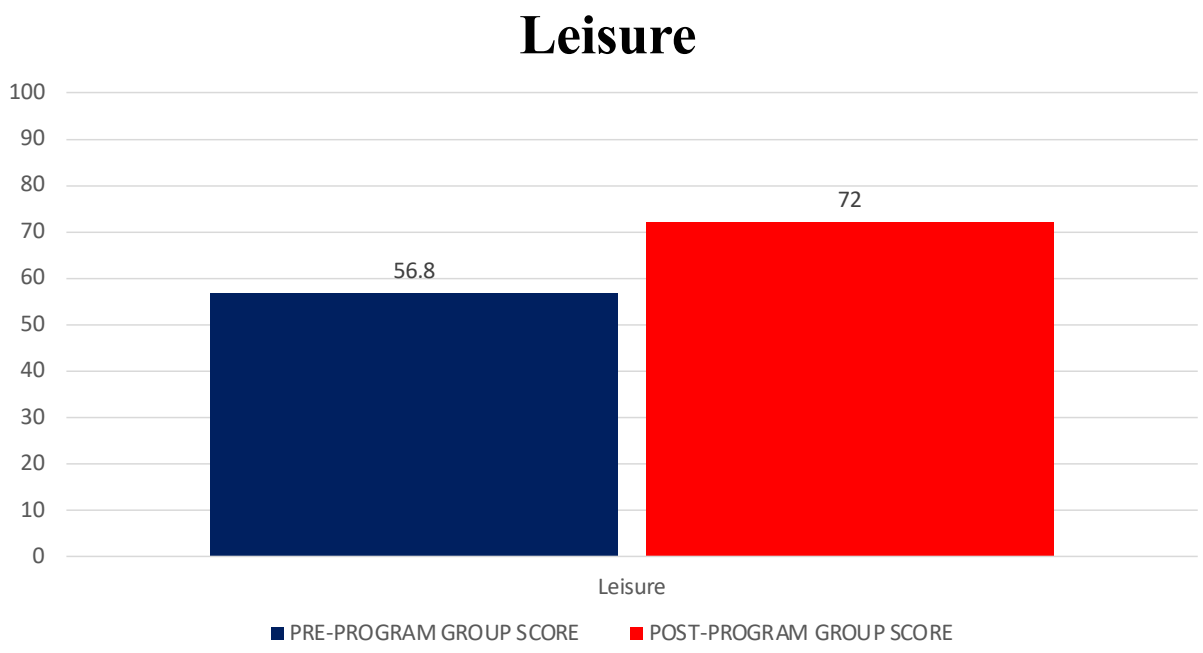
chapter also highlights how leisure generates positive emotion that serves to buffer the challenges associated with mental illness and increases resiliency against the adversity that is an inevitable part of everyday life. Finally, leisure was identified as having an intimate connection to well-being as it provides opportunities for the development of hope, identity, pleasure in everyday life, agency/autonomy and social connections; in this regard, leisure is a valued aspect of recovery and thus the work of Leamy and Colleagues (2011) should be extended to the CHIME+ framework (Anderson & Heyne, 2012a; Carruthers & Hood 2007; Hood & Carruthers, 2007; 2013; Hutchinson, Bland, & Kleiber, 2008; Hutchinson, Bland, & Kleiber, 2008; Kleiber, Hutchinson, & Williams, 2002; Kleiber, Reel, & Hutchinson, 2008; Kleiber, 1999; Lyubomirsky, 2007; Lyubomirsky & Layous, 2013).

The sixth subscale of the Wellness Evaluation of Lifestyle (Myers et al., 2004) was used to generate values for leisure. The leisure score is connected to the connection made to free time activities and living well within the BYBS-Y program, with an overall increase of 15.2%. While statistical analysis was not conducted to qualify significance of this score, the increase does provide some evidence that a change has occurred. For youth, leisure provides an unobligated space for them to explore development in the context of interests while generating the greatest possibility for positive outcomes and should hold significant value in the treatment process. The BYBS-Y program pilot results are a clear illustration of the potential impact of leisure-based interventions for youth, and further exploration is required in this regard.

Ahern and Norris (2011) found that extracurricular activities (leisure) were particularly valuable in decreasing stress and increasing resiliency in young people. In the phase one focus groups the participants actively described challenges associated with leisure engagement, suggesting that free time activities were inaccessible to them based on their current struggle, and

that simply attending to activities of daily living was physically and emotionally draining of their personal resources. It is possible that the decreased score in mood and emotion might be understood as a product of both circumstances on the date of the post-program measurement and lack of engagement in meaningful activities and yet, as will be discussed later, the overall leisure scores increased. Figure 7.6 provides a visual illustration of the leisure scores discussed in this section.

Figure 7.6 Leisure Scores



Well-Being

Chapter two identified literature that illustrated acceptance, hope, pleasure in everyday life, autonomy/agency, and social connection/engagement as central factors that support well-being. Increased levels of well-being are a primary focus of the therapeutic recreation profession and arguably underpins interventions across the lifespan. The BYBS-Y program was no exception to this, with the expectation that indeed the participants would experience an overall

increase in their mental health and wellbeing in congruence with their engagement in the recovery process.

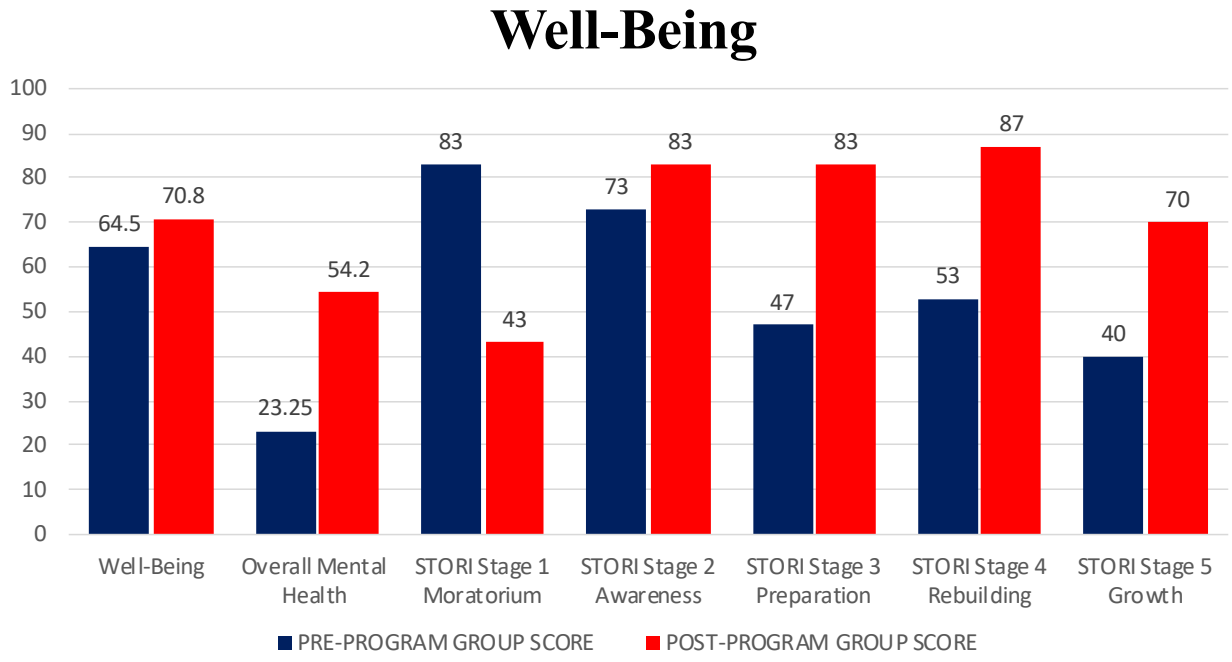
The Adolescent Mental Health Continuum – Short Form (A-MHC-SF) (Keyes, 2008) was used to generate the overall mental health value score, results of which revealed an increase of 30.95% overall. Congruent with this, the COMPAS-W Scale of Well-Being (Gatt et al., 2014) generated a composite score of well-being, results of which revealed an increase of 6.3% overall. While statistical analysis was not conducted to qualify significance of either score, the noted increase provides some preliminary support as to the value of the program overall. The increased mental health and well-being scores certainly support the potential effectiveness of the BYBS-Y program, illustrating the re-engagement of youth and the employment of strategies that served to support improvements. What remains unclear are the exact factors that contributed to this change, which will hopefully become clearer through future facilitation and evaluation of the BYBS-Y program.

The Stages of Recovery Inventory (STORI-30) (Andresen, Caputi, & Oades et al., 2006) was used to evaluate recovery progression, revealing that participants had all advanced at least one stage in recovery. Future facilitation of the BYBS-Y program will certainly serve to explore more explicit explanations for the decreased values on certain measures. Equally, the decreased values on particular items serve as points of reference as we begin to explore the BYBS-Y program further. It would be unrealistic for one to expect the nuances of the BYBS-Y program to be understood after the first pilot, however, what is clear is that there is some evidence to support the overall effectiveness of the program in congruence with recovery.

The increase in well-being scores provide some indication that the program is effective in supporting change and has an overall positive impact on participants. It is likely that this increase

is a result of many factors involving both the content and process of the BYSB-Y program and raises the question as to how the program will perform with a different group of participants and/or a different facilitator. The result of the mental health well-being measures are certainly encouraging, but equally should be taken at face value as the program needs much further investigation and measurement before reliability and validity can be determined. In the context of CHIME+ framework, the addition of well-being is directly related to the overall purpose of the BYBS-Y program and ultimately the goal of recovery-oriented care. Figure 7.7 on the following page provides a visual illustration of the well-being scores discussed in this section.

Figure 7.7 Well-Being Scores

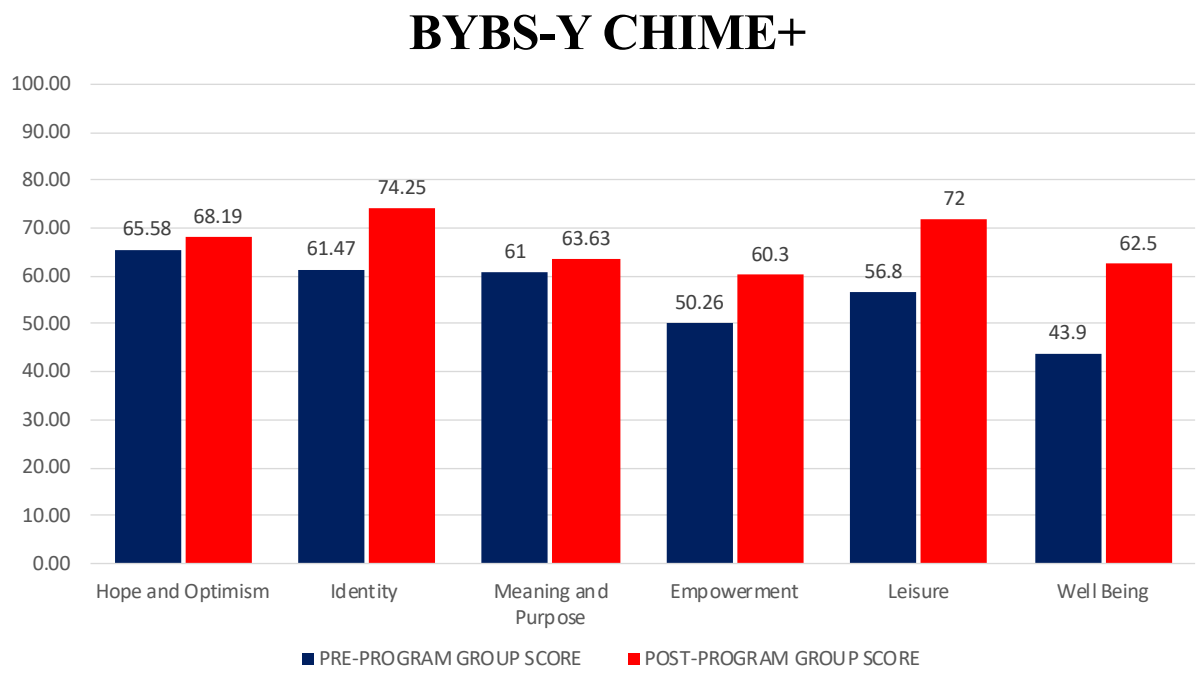


BYBS CHIME+

In this section of the chapter the overall impact of the program was explored through the CHIME+ framework. Through the application of this framework, there is a clear indication of positive effect. As illustrated by figure 7.8, which represents the scores for each of the previously

discussed categories, there is indication of improvement across all domains of the program, with varying degrees respectively. This does not negate the need for further exploration of the BYBS-Y program, but rather, suggests that indeed there is value in the current framework, with further exploration required before the impact is fully understood.

Figure 7.8 – Summary of BYBS-Y and CHIME+



Section Two: The Power of Strengths

This project highlights the contribution that TR service makes to adolescent mental health services and fills a critical gap in the mental health literature, supporting a more accessible approach to service provision that appears to be particularly effective with youth. This project sought to gain insight into the experiences of youth living with mental illness, with the goal of answering "*How might a therapeutic recreation intervention designed to [broadly] support the development of a positive personal narrative impact adolescents' perceptions of living well with mental illness?"* The design and findings from this project are relevant across the therapeutic recreation, mental health and adolescent developmental literature, highlighting the need for further exploration. This project provides some evidence that indeed the Be Your Best Self – Youth program has a positive impact on youth living with mental illness and was successful in promoting a positive shift for the small group of youth who participated. While I acknowledge that there is much more work to be done before the BYBS-Y program is fully understood in this context, this process has highlighted the value of a focus on strengths in creating therapeutic relationships with youth and particular approaches to facilitation that maintain safe spaces for doing so.

Connected to best practice in therapeutic recreation is the highlighting of one's capacities that can be harnessed to support change. A strengths-based approach to care involves a process of exploring one's aspirations, skills, values, and the surrounding environmental resources present which allow opportunities for success. Strengths can include the personal qualities that are inherently accessible in nature and highlight what is working, rather than what is not (Peterson & Seligman, 2004). They can also include the supports outside of the self that allow opportunities to (re)discover the positive aspects of one's self on the journey of recovery

(Anderson & Heyne, 2012b). In this regard, personal strengths can be relied upon to consistently produce positive outcomes, even in the face of adversity, thus connecting clients to greater functional experiences overall (Carruthers & Hood, 2007; Hood & Carruthers, 2007).

Zimmerman (2013) presented his resiliency theory as a framework for adolescent health and behaviour research and interventions. Within this theory, strengths are regarded as assets that change the trajectory of risk and maladaptive behaviours towards positive outcomes by highlighting the individual variables that make a young person unique. By focusing on contextual strengths that one possesses, the way in which young people perceive themselves can be effectively changed, resulting in a shift towards more desirable outcomes. This notion is well supported by Fredrickson's (1998; 2001; 2009; 2013) work, which focuses on the initiation of an upward spiral through the on-going experience of positive emotion, suggesting that the experience of gratification increases one's self-efficacy and facilitates the exploration of development that would otherwise reside outside of one's comfort zone.

The primary outcome of a strengths approach is to provide opportunity for clients to obtain their desired life. Exploring what is already working in one's life and their pre-existing capacities can shift expectations, allow clients to connect to the possibility that things could be different, and create space for the development of new capacities that support such change (McCaskey, 2008). Central to strengths-based practice is the process of helping clients to identify personal aspirations, set related goals and mobilize strengths towards the attainment of such goals (Carruthers & Hood, 2007; Hood & Carruthers, 2007). This process encourages autonomy and facilitates opportunities for self-directed care. Effective strengths-based practice involves a practitioner-client dialogue that creates a therapeutic connection and allows clients to feel understood in their current circumstance, while believing change is possible. By focusing on

strengths, the practitioner creates safe and inclusive environments that allow clients to connect to activities that are personally meaningful and provide opportunities for clients to establish behaviours that could support their best self (Anderson & Heyne, 2012b).

Intimately connected to strengths is the experience of positive emotion which was previously highlighted as a central part of living well. Chapter two outlined several benefits of positive emotion including the boost in one's overall functionality. In addition, positive emotion was presented as a mechanism for engagement which could be particularly valuable in the context of treatment services (Fitzpatrick & Stalikas, 2008; Fredrickson, 1998; 2001; 2009; 2013). In congruence with the findings from phase one (client values), and informed by the recovery, adolescent development and TR literature, personal strengths were a central focus of the BYBS-Y program providing participants with opportunities to familiarize themselves with strength-based language, identify personal characteristics, explore future aspirations, mobilize strengths towards achievements, inspire a sense of autonomy and facilitate opportunities for connections with others.

This project piloted a revised version of the BYBS program that was originally designed for an adult outpatient mental health population. This pilot program was informed by client voice, practitioner expertise and research evidence. However, the principal student investigator had some familiarity with the original BYBS program, having previously participated in the facilitation and observation of the program at a local hospital. This experience with the exercises and ongoing collaboration with colleagues and clients informed some anticipated results for this pilot project. In congruence with Nevo and Slonim-Nevo (2011), practitioner insight and experience are a recognized and valued part of evidence-informed practice, and this concept is one of the key factors that they suggest makes evidence-informed practice a more valuable

approach to effective care. Strengths-knowledge was embedded throughout the BYBS-Y program as a particularly important aspect of the program. Providing youth with the opportunity to explore strengths language and to connect it with their own experiences was of particular interest, as it was thought to be a key approach that would set the program apart from other offerings within residential service, thus creating a completely different clinical experience for the participants.

As a result of the implementation of the BYBS-Y program four functions of strengths-knowledge are illustrated: (1) the power of strengths in acceptance, (2) the power of strengths in managing illness, (3) the power of leisure in re-engagement, (4) the power of strengths in supporting change.

The Power of Strengths in Acceptance

Acceptance was presented in chapter two as central to the acquisition of a better life and foundational to the ability to navigate the challenges associated with mental illness (Hayes, Pistorello & Levin, 2012). Acceptance is the art of embracing what is, while creating space for the possibility of what could be (Cripps & Hood, 2017). Acceptance in this context is about creating space for the unwanted thoughts, feelings, urges, etc. to be present until they pass, without resisting them or avoiding things that could bring them up. Acceptance is central to the possibility of a better life, as it allows one to live beyond the confines of their illness (symptoms) and to develop the capacity to navigate challenges associated with them as they arise. Turrell and Bell (2016) suggested that fear of failure, pain and suffering often are barriers for teens when it comes to mental illness, as they have often not had adequate opportunity to connect to their ability to overcome challenge or achieve goals while Shatkin (2015) noted resiliency as a determining factor for youth living well with mental illness.

Exploring strengths in the context of treatment creates the opportunity for acceptance by allowing acknowledgement that even in the face of illness, all is not lost. When people are able to (re)connect to the things they are good at and to experience moments of positivity and ease, they in turn open the door to the possibility of an identity that is defined by ability but can include illness. In the post-program focus group, the participants spoke of the positive experiences associated with strengths discovery, while noting the importance of allowing their illness to still be part of who they were. The intersection of illness and identity has been explored by Davidson and colleagues in a series of qualitative studies, (Davidson & Strauss, 1992; Davidson et al., 2005; Davidson et al., 2009) in which they described the process of constructing a new sense of self as a central aspect of recovery as it creates a more balanced narrative that allows for one to attend to their care needs without excluding other aspects of life that exist outside of mental illness. In essence, this shift involves the externalization of illness – "I am a person with a mental illness" vs. "I am mental illness".

In the context of the BYBS-Y program, a balanced narrative is initiated through the demonstration of one's ability to include illness as part of the self, but not be defined by it. By creating opportunities for youth to accept challenges through the exploration of strengths and capacities, space is created for the participants to begin to connect to the possibility that life could be better. The development of strengths knowledge allows space for one to consider new opportunities and to connect to one's desired life. By examining our strengths we cast new light on our struggles which births possibility, values and hopes. Through a strengths lens, we are able to then accept the challenges faced by better understanding of how our challenges highlight strengths that in turn generate new opportunity for growth (Saleebey, 1996). This is not to say that a strengths perspective lessons the impact of illness, but rather it allows opportunity for

clients to shift their focus in a more positive direction which in the immediate, provides relief from challenge, and in the distance opportunity for change. Throughout the BYBS-Y program the participants were quick to express understanding of illness, often noting that their best life included the capacity to buffer illness related symptoms, not eliminate them.

The Power of Strengths in Managing Illness

Recovery from mental illness is a journey of self-development that incorporates mental health as an aspect that requires an ongoing commitment to care but is not defined by it. For youth, recovery begins with managing the biological symptoms associated with their illness. In fact, well-managed symptoms are required before a client is be deemed to be appropriate for residential treatment services in Niagara. The premise behind this is not to discourage youth from entering treatment, but rather out of recognition that the psychological/emotional aspects of illness are more challenging to treat effectively when compromised by biological inequity. Managing illness includes both symptoms and the ability to tolerate distress, both of which are foundational to one's ability to begin to engage in the recovery process.

Living well with mental illness is not the absence of symptoms (Andresen et al., 2011). Symptom management is about finding ways to create a greater sense of balance within one's self (Davidson, 2003). In many cases, this is supported by a combination of strategies that begin with pharmacological intervention in an effort to manage the biological processes that affect brain chemistry. Cripps-Torok (2014) found that participants spoke quite often of their need to attend to basic necessities which include: medication, adequate sleep, nutrition and exercise. This knowledge informed many of the informal discussions made throughout the BYBS-Y program as youth began to envision what they believed living well might look like for them.

Throughout the facilitation of the BYBS-Y program the participants spoke often of the medications they took to help manage illness-related symptoms and were quick to reference this aspect of self-care as a strength they had developed as a result of their illness. In addition, the purposeful integration of physical activity was identified as a strategy they used for coping with some of the frustrations they experienced in treatment. Located in the basement of the residential treatment facility was a heavy bag, suspended from an exposed beam. The staff taught clients how to properly wrap their wrists in preparation for using it. This interest in boxing transferred into the BYBS-Y program through discussions of the value of leisure in the context of mental health. One participant described to the group the release they feel when channeling their anger they feel into something positive, and the subsequent interest they now have in the sport of boxing. Within the BYBS-Y program, discussions surrounding self-care were unstructured but often brought up by the participants as they explored free time activities.

Consistent with Gander et al. (2013) there was some indication from the focus groups and program implementation, that managing symptoms aligned well with the strengths approach, as managing illness requires one to focus on the aspects within their control in order to make changes. Although the manifestation of symptoms is difficult to control, response to symptoms is a choice. Choice in action is of particular value for the adolescent population, as it creates forward movement on the quest for autonomy (McLead, Uemura, & Rohrman, 2012).

The phase one focus group raised questions about the need for distress tolerance skills and whether the participants had been given past opportunities to safely develop the skills necessary to tolerate uncomfortable emotion. Distress tolerance involves the development of a set of skills that can be put into action when one faces situations that are difficult or impossible to change (Linehan, 2015). These skills help individuals to cope with crisis and to tolerate both

physical and emotional pain (Linehan, 2015). Throughout the implementation of the BYBS-Y program it was consistently noted that the participants lacked the ability to navigate uncomfortable emotions. The participants often described extreme reactions to uncontrollable circumstances, resulting in high levels of frustration, anger, sadness and pain. Their inability to navigate this discomfort then mediated their engagement in non-suicidal self-injury (NSSI) behaviours including cutting, scratching, picking, and excessive rubbing. These conversations often took place in the context of leisure engagement and how leisure can serve as a mechanism for coping with uncomfortable emotion that might provide similar release to what the participants described experiencing with cutting, but without the infliction of further pain.

Nock and Mandes (2008) explored the connection between self-harming behaviours and distress tolerance skills concluding that young people who self-harm are less engaged with distress tolerance strategies, even when presented with the opportunity to learn them, as self-harming behaviours often serve more immediate gratification. Although there is literature that explores self-harming behaviors from youth perspectives (Nock & Prinstein, 2004; Rodham, Hawton, & Evans, 2004) there is still a lack of understanding as to whether these individuals have a lower threshold for distress that predisposes them to these outcomes.

Thompson (2011) suggests that emotion is the collision of one's neurobiological and behavioural systems, with change only occurring when both systems are involved. The development of distress tolerance skills aligns well with the strengths approach, as it allows the opportunity for youth to redirect their attention towards things over which they can have control (Linehan, 2015). In fact, the Leisure and Well-Being Model (LWM) of therapeutic recreation (Carruthers & Hood, 2007; Hood & Carruthers, 2007) and the ecological extension of the LWM (Anderson & Heyne, 2012a) provide evidence that emotional expression and regulation are well

supported through leisure engagement. Tolerating uncomfortable emotion through leisure engagements that are meaningful is likely to alleviate discomfort and creates the possibility for gratification and/or the generation of positive emotion.

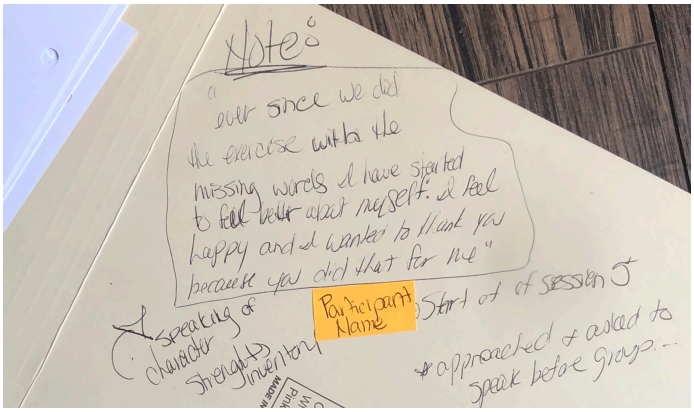
Similar to the notion of unmanaged symptoms, distress tolerance skills developed through strengths provide people with a toolbox full of instinctive responses that highlight what is working for them, despite the challenges faced (Linehan, 2015). Generally, individuals experiencing crisis are less keen to seek out further challenge and, given this, in order for one to tolerate uncomfortable emotion, they might naturally gravitate to things that distract them from or alleviate the discomfort they feel. In this way, distress tolerance skills are often rooted in the understanding of intentional activities and personal strengths, more than the development of specific leisure skills.

The Power of Strengths in Re-Engagement

The notion of living well with mental illness was discussed in the phase one focus group, supporting that friends, leisure, a sense of hope for the future, school-based accomplishments and romantic relationships were all valued aspects of everyday life for the participants. This knowledge informed discussions throughout the BYBS-Y program and generated many meaningful conversations throughout the eight sessions. In weekly field notes there were notations about living-well with mental illness and the various ways in which the participants experienced futuristic thinking surrounding such achievements. For the participants, envisioning a life that is socially and romantically connected was referenced in the context of dysfunction (what's missing) and as reason for getting well. As we explored this disconnect in our group discussions, it became rather clear that they envisioned a valued life as mediated by social

connectedness, achievement, independence and knowledge of self, all of which are well facilitated by strengths (Hood & Carruthers, 2016a; 2016b).

One participant often spoke of not knowing who they were, and not having any strengths. This participant's self-deprecating dialogue was noted in several field note citations as being particularly challenging from a facilitation perspective. As illustrated below, after four sessions focusing on strengths in various ways, this participant voiced a significant shift in their self-worth, thus illustrating how a strengths approach can re-engage someone and create opportunities for envisioning the possibility of change. Prior to the start of session five this participant approached me to express gratitude for the change they were beginning to experience through the BYBS-Y program:



"Ever since we did the exercise with the missing words, I have started to feel better about myself. I feel happy and I wanted to thank you because you did that for me"

Following this breakthrough, this participant's engagement shifted from low to high, less self-deprecating comments were made and expressed hopefulness for the future was noted. In this context, exploring strengths allowed participants to explore what was working, and to connect to the capacities that might support the attainment of a positive social network, increased academic success, positive free time engagements and sense of hope for the future.

The Power of Strengths in Supporting Change

The Transtheoretical Model (the Stages of Change Model) supports change as a complex process that involves a series of stages that people move through in order to support the acquisition and maintenance of new behaviours (Prochaska & DiClemente, 1983; Prochaska, Redding, & Evers, 2008). Briefly, change begins with a desire for something to be different and the belief that improvement is possible. Next the individual is tasked with learning new ways of behaving and then translating this learning into practices that support new behaviours. Over a period of time, the individual affirms their commitment to maintain the behaviour change to prevent relapse (regression) back to an earlier stage.

In the context of the BYBS-Y, change involves focusing on purposeful activities that improve awareness and identity, harnessing pre-existing capacities and highlighting one's full potential. The program is designed to support a shift towards positivity, coping and overall satisfaction in everyday life. Literature supports that individuals who feel competent about who they are and are connected to their skills and capacities are more likely to take risks, explore new experiences and create space to evolve into their best selves (Deci & Ryan, 2000). In this regard, by exploring strengths in the context of free time activities, the BYBS-Y program provided the participants with the opportunity to connect to their competencies, exercise a sense of control and explore connections with others. The BYBS-Y program thus served to support the needs deemed necessary to facilitate change and was voiced by participants as having a positive impact on their ability to believe that living well with mental illness was possible.

Through the integration of an evidence-informed framework, it is possible that improved client outcomes were generated as it accounted for individual preferences by giving voice to clients before and after the program. By highlighting the unique concerns that set the participants

apart from others potentially redirected some of their previous challenges faced in therapy, enhanced the therapeutic relationship and made the program meaningful for the participants.

Section Three: Facilitation Related Findings

There were several unanticipated findings that resulted from this study that were rooted in the application of the evidence-informed process and the experience of supportive facilitation techniques, both of which expand the value of this project. This section will further discuss these unanticipated findings and highlight the significance of each.

Evidence-Informed Practice

The development and evaluation of services was undoubtingly a valued outcome of this project. In particular the experience gained through the employment of an evidence-informed framework has the potential to strengthen TR and mental health practice, as this process has received minimal representation with little attention paid across the bodies of mental health or TR literature. As described in chapter three, a seven-step evidence-informed process was used (Drake, Merrens, & Lynde, 2005).

In step one, the problem of youth struggling with mental health challenges was identified. In step two, evidence to support the problem was collected. In congruence with Drake and colleagues (2005), evidence from three sources was gathered. First a review of scholarly work was conducted, then client voice was solicited through the employment of the phase one focus group and finally clinical expertise was sought out for feedback on the BYBS-Y program. In step three, the evidence was critically appraised using qualitative analysis and descriptive statistics. In step four, the findings were appraised and translated to inform final decisions on the BYBS-Y sessions. In step five, the BYBS-Y program was piloted with pre-and post-program measures were collected. In step six, the impact of the program was evaluated using the descriptive statistics generated from the pre- and post-program measures and the social validation session scores. Next the post-program focus group was analyzed using qualitative methods which led to

the identification of several common themes. Finally, the results of the BYBS-Y program were disseminated through several outlets including professional conferences and the authorship of this dissertation. Following defense, these findings will be submitted for publication to an academic journal to further the process of dissemination.

The impact of this experience holds potential benefit for helping professions on the micro and macro levels of clinical practice. Implementing EIP at the micro level has the potential to change the daily approach to client care, as practice becomes informed by new knowledge that includes space for practitioner expertise and client voice. In this regard, EIP is well aligned with recovery as it recognizes individuality and embeds clients' views and preferences into services that best support their desired outcomes for living well. At the macro level the EIP process can inform changes such as new approaches to programming, changes to scope of practice within professional guidelines or the adoption of a new model of care, as it provides a framework for evidenced-based practices to be translated and explored in new populations and settings without compromising best-practice within a particular discipline. Finally, as exemplified by this project, the EIP process can support partnerships with academic institutions that inform new and/or improved client care and ultimately serve to support the greater community at large.

Group Facilitation

> *The thing with services is that you never really know what is going to work for you and what isn't. If you were to ask me a few years ago, I would have told you that therapy doesn't work, but really it was the therapist I had that didn't work for me. I don't think it's so much about the services we receive, but the people we receive them from. (phase 1 focus group)*

In the phase one focus group, the participants actively described counter-therapeutic experiences in treatment and subsequently prescribed a recipe for being “a good therapist”. I approached the BYBS-Y facilitation with some content-based experience that made the translation of knowledge feel comfortable and this comfort is what allowed me the opportunity to explore what it means to be an effective leader.

An intention to create a culture within the group that generated a sense of belonging, facilitated safety and inspired courage was inspired by the phase one focus group. In preparation for this, I re-visited Brown’s (2010; 2012; 2017) work on vulnerability, shame and effective leadership. The following is a discussion of the five facilitation-based findings that were brought to light in the post-program focus group.

Shannon and Kafer (1984) explored the experiences of neglected and rejected children and responsive strategies in relationships, identifying that children who do not regard trust as an important component in relationships struggle within peer groups and participate in unhealthy relationships with others. In fact, Brown (2018) suggests that the greatest casualty of trauma is trust, through which the courage needed for learning is lost too. Building an environment of mutual trust and respect was a central aspect of facilitation for the BYBS-Y program. The experiences described by the participants have been broken down into four themes: (1) authenticity; (2) creating safety; (3) valuing process over content; (4) meaningful leadership.

Authenticity.

> *It is really obvious to me that you’ve put your heart and soul into this program and into making a difference for us and it’s pretty incredible to meet someone that isn’t just doing it for the sake of their job, or because they have to for school. It felt like we mattered to you, and that made it easier to learn*. (post-program focus group)

Joseph (2016) outlines particular traits associated with authentic people, as identified within the humanistic psychology literature. Briefly, authentic people are said to carry realistic perceptions of the world around them, practice self-compassion and are accepting of others. Authentic people are thoughtful and carry a sense of purpose that is connected to a deep understanding of their motivations. Authentic people are willing to make mistakes, and to learn from these mistakes. Authentic people are able to express their emotions freely and show particular understanding of such.

Brown (2010) defines authenticity as "the daily practice of letting go of who we think we're supposed to be and embracing who we are" (p.50). It is a way of being that involves commitment to the cultivation of courage, connection, compassion and gratitude. Being authentic in many ways is part of recovery, as it involves a heightened sense of self and a unique ability to recognize your strengths, capacities and values in relation to those around you.

Authentic practices were woven into the BYBS-Y facilitation purposefully, when participants asked questions, honest answers were given. Kindness, compassion and generosity were practiced in order to model a sense of vulnerability that humanized the time spent with participants. The participant descriptions in the post-program focus group were congruent with this approach and supported feelings of safety while creating a sense of belonging within the group.

Creating safety and trust.

One of the best things a therapist ever said to me on my first session was "I'm going to tell you a bit about myself and then we're going to talk about you, is that okay with you?"…it made me feel like I wasn't pouring my life story out to complete stranger, yet again";

"When therapists express the fact that they are human and have human emotions, it helps a lot because feeling like they're not makes it harder to talk – (phase one focus group)

There are a number of factors that contributed to creating safety in the group during the BYBS-Y, including vulnerability, reciprocity, trust, sameness, and belonging. Brown (2012) suggests that vulnerability is the birthplace of love, belonging, joy, trust, empathy, creativity and innovation. There is a reciprocal relationship between vulnerability and safety, the modeling of vulnerability creates safe environments for others, while feelings of safety give individuals the courage needed to display their own vulnerability. In essence, vulnerability is how we grow. When we belong, we become open to creating relationships, and in turn we begin to explore how our own needs are served in the contexts of others and gain further insight into ourselves. In contrast, when we feel like an imposter, we instinctively self-protect and in doing so we disconnect from ourselves and those around us. Cripps and Hood (2016) recommend the use of reciprocal dialogue that displays authenticity and supports the development of trust and safety in helping relationships. "We believe there is an ongoing exchange between one's ability to convey empathy, support and acceptance, and the ignition or dampening of a helping relationship" (p.12).

Feldman (2009) suggests that sincerity, reliability, competence and care facilitate one's conscious choice to trust, through which we generate intended outcomes. In this regard, trust is an all or nothing phenomenon. When an environment feels safe, trust begins to grow. Trust is mediated through safety and actions (Brown, 2018). One must experience safety before relationships can progress but when present, trust, hope, curiosity and generosity then emerge. In addition, trust facilitates cooperation, collaboration, conversation and a willingness to examine one's own actions (Langley & Klopper, 2005). And trust is associated with sustained levels of

oxytocin and the availability of the neocortex (thinking brain) thus the provision of optimal engagement, and arguably the highest probability for change (Feldman, 2009).

In congruence with Cripps and Hood's (2016) notion that facilitating a sense of sameness can be a tool that conveys empathy, the participants suggested the behaviours that mediated their trust were the unspoken actions that paralleled their privileges within the house. "*You [facilitator] took off your shoes at the door, even though adults wear shoes and that made me feel respected*"; "*You didn't drink coffee or eat in the living room, even though staff were allowed*"; "*you sat on the floor and you wore normal clothes*". Interestingly, the staff often displayed an authoritative approach when interacting with the participants throughout the program, albeit with the best intentions. These interactions served to shut down the process of group, rather than redirect it. Gottman's (2011) work comes to mind when reflecting on these moments, as he suggests that trust is built and broken in the smallest of moments. In every interaction there is as much opportunity to connect as there is to betray. In this regard, trust becomes a conscious choice that allows us to be vulnerable to the actions and criticisms of another (Brown, 2012).

Valuing process over content. Valuing process is rooted in the idea that developing and maintaining relationships with participants far outweighs the need to "stick" to the content planned out for that day. This approach to therapeutic environments is similar to that of semi-structured interviews, where a researcher has a particular plan, but leaves space for meaningful exploration as they see fit. In both contexts, curiosity is a driving force behind the experience. In a therapeutic context, Brown (2010; 2012; 2017) suggests conversations that best support change are initiated from a position of curiosity and generosity. Authentic curiosity involves one's

ability to identify and focus on a gap in their knowledge and requires reflexivity, while generosity is the practice of believing that others are doing the best they can in the moment.

The participants were often tangential during the BYBS-Y sessions, with personal conversations intersecting with the program content and excitement from aspects of their day thwarting their capacity to engage. In these disruptive moments helping professionals are often encouraged to redirect such behaviour in an effort to stay on task. However, in doing so, there is a risk that the therapeutic relationship may be ruptured. In the post-program focus group the participants described valuing such experiences, "*You allowed us to get off topic without yelling at us. It's like you realized we are teenagers and we're going to do that, but by not yelling at us, you gave us the chance to recognize when we did it and bring ourselves back*" with another echoing, "*ya, I didn't really think about it until now, but by letting us have that freedom, it kinda made us come back quicker.*" In addition, the participants suggested that the fluidity of conversation and the facilitator's willingness to meet them where they were at served to heighten their understanding of concepts: "*It was also pretty cool when you would join the conversation with us and help connect our bitch-fests back to stuff we'd talked about already, because that made it make more sense.*" In this regard, it is also possible that valuing client experience over specific learning plans could deepen the therapeutic relationship shared.

Meaningful leadership. Bass (1990) was one of the first to describe leadership across a continuum from passive to active suggesting the styles to be complimentary to one another rather than hierarchical. Polarized to one another are laisse faire leadership (most passive) and transformational leadership (most active). Northouse (2016) suggests that transformational leaders have a strong set of internal values, and the capacity to inspire those they lead to adopt similar ideals, while instilling a sense of agency within the group. Transformational leaders are

regarded for modeling the behaviours they expect of others while maintaining congruence between their thoughts and actions. They encourage others to bring their own creativity into a culture, encourage collaboration and use individual strengths within the group to solve problems that ultimately serve greater outcomes. Finally, transformational leaders have the capacity to negotiate between the group and the individuals who make up the group, recognizing that individuals often have a core set of aspirations with desired outcomes for change.

In congruence with transformational leadership theory, Brown (2012) presents BRAVING as an approach to leading. Briefly, this model represents seven elements for establishing and maintaining trust: B-boundaries emphasizes the need to establish manageable limits within any relationship; R-reliability emphasizes the need for follow-through and congruence, this involves establishing and maintaining realistic expectations and being mindful of one's own commitments, limitations and priorities; A-accountability emphasizes ownership over mistakes, rather than the need for perfection; V-vault emphasizes strict adherence to professional and personal confidentiality, inclusive of gossip; I-integrity emphasizes courage, and practicing what one preaches; N-nonjudgement emphasizes safety in conversation; and G-generosity emphasizes unconditional positive regard, and a willingness to assume good intentions. In the post-program focus group, the participants described experiences that align with elements of Brown's (2012) BRAVING approach, which in turn facilitated the opportunity for them to develop similar skills. This experience illustrated the importance of effective facilitation and meaningful content, which was not something at the forefront of the discussion when this project was being conceptualized.

Section Four: Reflection and Future Direction

Personal Reflections on the Process of Field-Based Research

No research is free from limitation and this project was no exception to that rule. The youth participants were all sourced through a local residential treatment facility and therefore represent a particular group of individuals within the youth population. Although it is possible that if a program can demonstrate effectiveness with those who have not found any other successful treatment, then it must hold value. I am equally curious to pilot this program in an outpatient setting where there are fewer environmental controls present as it is possible that the mere culture of a residential treatment facility augments the success of treatments in general. The intention of this project was not to create generalizability, but rather to explore the value of the BYBS-Y program to support implications for future research and/or therapeutic recreation practice and indeed this was accomplished. Not only has this project provided significant insight into youth experiences, it also has given new thought to how one might better serve effective program development in mental health services.

Joseph and Murphy (2013) call for epistemologically congruent measures when approaching psychological support from a person-centered approach. They suggest it is possible that the traditional measures of change are less relevant to a positive psychology approach and this discourse has led me to question whether or not additional measures should be added to evaluate the facilitation component of the program. Although I did not anticipate that the participants would ascribe particular meaning to the facilitation itself, it appears as though the effectiveness of a program is impacted by both content and process.

My intention with focusing on purposeful facilitation was an effort to uphold my own personal values with regards to client care. I felt an immense sense of privilege for the

opportunity to work with “real people” throughout this project. Action-based research allowed my interests to come to life (literally), and yet was also a huge responsibility. In looking back at the phase three tools, I regret not having a sixth item on the social validation questionnaires that targeted facilitation. It would have been interesting to compare the mean score on this item to the field notes and post-program focus group narrative to better understand the values held within the experience.

When the BYBS-Y program was conceptualized, it made sense to explore the program using the same evaluation tools as the adult version, as I was mindful of parallel studies taking place with the adult population. The fieldnotes supported differences between the youth and adult experiences in that the sessions noted to challenge adults did not challenge youth and vice versa. As such, I think there would be value in comparing the results from this pilot to the results of the adult program, as it may inform a deeper understanding of the unique needs of each population.

Since the initial design in phase one, I have thought about additional changes I would make to the program, in particular if I was to extend the program and deliver it in an outpatient setting. First, I would add a component that addressed the impact of social media on sense of self. Although the BYBS-Y program did not directly address this issue, group discussions often led back to daily challenges with social media. Interestingly, Joseph (2016) highlights that tangible references of authenticity are becoming increasingly necessary, as technological advances such as social media continue to “present the world as an electronic image” (p.219). As evidenced in this project, having an authentic facilitator created space for positive connection and mentorship, by using this space to explore social media perhaps the BYBS-Y program and culture could serve to inspire healthier habits in this regard.

In congruence with Cripps-Torok (2016) I would also explore positive sense of self in the context of self-compassion and include the Unconditional Positive Self-Regard Scale (Patterson & Joseph, 2006) as I believe this is an essential skill for recovery. As well, I would include a session on the authentic self and use the authenticity scale (Wood et al., 2008) as a means of exploring this personal connection to self.

This project is deeply rooted in my passion for mental health advocacy, the desire to give voice to others, and the belief in the evolution of best possible services. While I believe the impact of this program has the potential to change the way we approach mental health programming for children, adolescents and adults, I also acknowledge this was a resource intensive exercise that may require some practical revisions to the data collection process which might mean a less formal process for phases one and two. I believe that in life and in learning, there is no linear path nor is there a singular approach. This project is not a one-size fits all solution to effective program design. It is a demonstration of how one might approach the improvement of services, should they be so daring.

Over the past two decades I have not followed a traditional path to my doctoral studies, and this experience is what made me a valuable asset to this project. Fifteen years ago, I was a young adult lost between the cracks. My invisibility at that time and my subsequent journey of creating a life of meaning informed my ability to relate to and appreciate the challenges my participants expressed. I have had the fortune of overcoming incredible personal and professional obstacles in my life and career, and that adversity informs my desire to re-humanize the world around me, so others can connect to opportunities for change. In my masters thesis (Cripps-Torok, 2014), I told my own story of mental health and recovery, findings of which inspired my doctoral project. Sharing my story left me with a deep sense of vulnerability that I have now

replaced with immense pride, as this journey is so much more than a doctoral project yielding my final degree. When I began, I had a passion for mental health and a burning desire to prove to myself and the world around me that despite my own challenges, I could do something great. What I have come to realize on the other side, is that my need for such accomplishment helped me understand the participants the BYBS-Y program and this process has become part of my own recovery.

Becoming a parent amidst this degree also changed my desire to make a difference in the world. In my proposal, I was asked what I hoped to accomplish with this project, and quickly articulated my desire to pay forward my own experience with mental health and in hopes of making a difference. Now that my project is complete, my work no longer feels like it is simply about learning, rather, it became process of meaning making outside of my most important role, while creating the possibility of improved services that might better support future generations. As a mother, I hold interest in the youth population, and that makes these services even more important to me in both personal and professional contexts. Throughout this project I struggled with keeping my own story separate from the voice of others, and yet I believe that my capacity to make meaning from my own lived experience and use it to convey a sense of empathic curiosity and understanding is what ultimately supported my success as a facilitator.

Not having a body of literature to access that would guide this process was equally as intimidating as it was exciting. At times, this project felt bigger than me as I navigated my way between the micro and macro levels of it, and yet, on this side I have gained great clarity into the relevance of evidence-informed process and how this experience has the potential to translate into improved mental health services in the future. This project used the lens of therapeutic recreation, as it aligned with my professional training and core values with regards to living well.

I fundamentally believe through both my research and my lived experience that what we do in our free time has the potential to enhance our functionality across all domains and ultimately increase our overall quality of life. Having the opportunity to lead young people at the beginning of their own journey in recovery was an honour and a privilege and hearing them articulate the change they began to feel made the blood, sweat, and tears that came with this project worth it.

Transferability of the program

BYBS-Y is a therapeutic recreation intervention, that focuses on the employment of one's strengths in order to begin to support the development of a positive identity. As evidenced by the phase three pilot evaluations results, there appears to be value for this program within the youth mental health population. However, it is also clear that there is a connection made between effective facilitation and meaningful program content in order to engage the participants in the process.

Throughout the BYBS-Y program there was particular emphasis made on the supportive facilitation which served to create an environment of mutual respect and overall positive experience. While there is specialized training required to effectively support the content of the program, there is certainly generalizability for the facilitation experience extends well beyond the therapeutic recreation profession and mental health arena. Since completing this project, I have had the opportunity to engage in critical conversations and share my learning with educators, parents, health practitioners and members of the community. My message in this regard is simple: Youth, like adults, want to feel respected for their knowledge, experiences and practices. If we are to effectively support youth development, we must shift from prescriptive to collaborative interventions and be human within the experience. While the facilitator will always hold expertise with content of a program, the clients will also hold expertise with the

facilitation experience – neither is more valuable than the other, thus, the union of such experience yields voices of equal value.

Future Directions for the BYBS-Y Program

This project explored the impact of a strengths-based intervention and provides evidence that the BYBS-Y program has the potential to support change with the participants. This project demonstrates new learning and is an illustration of the potential connection between a strengths perspective and supporting essential tasks assigned to development and recovery. By implementing a three-phase process this research shows the value of feedback from both practitioners and clients, affirming that our greatest insights are always gained from those with lived experience. Finally, this project provides evidence for the contribution of TR services in the recovery process, suggesting that by focusing on the development of skills and capacities that are likely to generate emotion, highlight strengths, support choice and create opportunities for positive social connections, it is likely that youth can increase the resiliency necessary to buffer the effects of chronic symptoms and in turn begin to envision (and obtain) a life that includes, but is not defined by illness.

The participant narratives from the post-program focus group were suggestive of positive change as the participants were able to verbally express a shift away from self-harm and suicide and envisioning more positive outcomes for their future; were able to demonstrate the ability to make the connection between identity, narrative and leisure; and were able to describe themselves using strengths-base language. This preliminary evidence is further supported by the descriptive statistics generated from the pre and post assessment tools, which revealed trends in the graphs that are suggestive of change towards increased levels of mental health.

Moving forward this program will need to be facilitated a few more times in order to better understand the trends set by the results and those trends could then be explored alone and relative to the original adult program. Chapter six informs changes that could be made to several sessions which might be best explored through another pre-program focus group to ensure that such changes remained aligned with the client values. Given that the BYBS-Y program was created for outpatient psychiatry, it might also be interesting to explore the youth program in an outpatient environment to better understand the setting in which it proves most effective.

The BYBS-Y pilot clearly held value for the participants, and the pre- and post-program assessments showed evidence of change across several aspects of self. It was previously suggested that circumstance may have been a considerable factor for the unchanged and decreased scores, and this can only be explored through future implementation of the BYBS-Y program. In addition, longitudinal and comparative evaluations with the data from the BYBS-Y adult program might serve to better understand the innerworkings of the program as well as the clients accessing it.

Throughout this project, participants described hope for a future that was underpinned by companionship. Moreover, the employment of purposeful facilitation strategies created an environment through which the participants explored meaningful connections with others and this combination of trust and companionship appeared to support successful engagement with the program content and resulted in change. There was a reciprocal process that took place, as personal value (sense of worth) increased, the participants began to explore deeper connections with themselves. By nature, we all crave connection and validation and it is possible that this basic need is at the root of effective interventions. For me, one of the most fundamental lessons learned from this experience is something I will carry with me in my future career: *people, youth*

in particular, will invest in others who they feel are invested in them – feeling seen matters, and when we armour down, we re-humanize spaces and allow opportunities for change!

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